Review of compliance

The Georgians (Boston) Limited The Georgians (Boston) Limited - 50 Wide Bargate Boston	
Region:	East Midlands
Location address:	50 Wide Bargate Boston Lincolnshire PE21 6RY
Type of service:	Care home service with nursing
Date of Publication:	March 2012
Overview of the service:	The Georgians is a care home located in the town of Boston providing care for up to 45 people. It is registered for the following regulated activities:- accommodation for persons requiring nursing or personal care, treatment of disease, disorder or injury and diagnostics and screening. It provides care for older people, those with

	dementia, a physical disability or mental health problems.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

The Georgians (Boston) Limited - 50 Wide Bargate Boston was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 3 February 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

When we visited the home we found that there was a newly appointed matron/manager in place who had only been in post for a short time.

During our visit we looked at the care being delivered in the service and spoke with six people, two relatives and members of staff.

Some of the people that we spoke with were unable to answer direct questions about their care and welfare, so we spent time observing how people were having their care needs met to help us gain a view on the experiences of people living at the home.

The people we could communicate with told us that they were respected as individuals and could make their own choices. Staff showed them respect by knocking on the doors of their rooms and we saw they waited before they entered. However, we did see evidence that people with memory loss were not always treated in the same way in that sometimes they were not acknowledged or spoken with by staff.

People told us they were happy with the care they received and said that staff were very good to them and kind. One person told us "I can't fault the home at all."

However, care plans were not easy to follow and we found that there were inconsistencies in some care practices.

People told us they felt safe in the home and we found that staff knew how to protect them

and what to do if an allegation of abuse was made.

Staff felt supported by the matron/manager although they had not received regular and documented supervision. People in the home felt the staff knew what they were doing.

People we spoke with told us were very happy in the home and did not want to change anything although we found that regular auditing of processes and systems had not taken place.

What we found about the standards we reviewed and how well The Georgians (Boston) Limited - 50 Wide Bargate Boston was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People are generally involved in making choices about their lives and are respected although there are some inconsistencies in practice.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People received the care and support they needed to meet their physical needs. However shortfalls in the care plans, especially for those with memory loss, could lead to people's needs not being fully met.

Outcome 07: People should be protected from abuse and staff should respect their human rights

People are safe and protected by robust systems and knowledgeable staff.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Staff benefited from a manager who supported them and they had attended training sessions in order to promote people's health and welfare. However, thay had not received regular and documented supervision.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The monitoring of quality in the service was not robust enough to ensure that risks to people's health, welfare and safety were identified and reduced.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
All the people we spoke with told us they were happy with the care they received and staff treated them with dignity and respect. One person said "I am given the opportunity to make choices like what clothes I want to wear." This person also commented that staff respected their privacy and dignity and when we saw that staff knocked the door before they went into their room they told us that "Staff always do that."

A relative we spoke with said that their loved one was always given privacy and dignity when it was needed. Another person told us they had their choices respected by the staff, for example accepting that they did not want to go into the communal lounges and preferred to stay in their room.

The people we spoke with also told us that they were encouraged to do as much for themselves as they could to remain as independent as possible and that care staff always explained things to them and helped them when it was needed.

Two members of staff we spoke with told us that helping the people who lived in the home to make their own choices was important. They told us how they did that, for example giving them choices about what they ate and what they wore each day. They told us they respected their decisions.

The two relatives we spoke with told us they had visited the home before their loved ones were admitted to make sure they were happy with it. They both told us they had been impressed with the care they saw and the information they had been given. However, when we sat and watched the care being delivered to people in one of the lounges we saw that two members of staff did not acknowledge or speak with them when they entered the lounge or did tasks for them.

Other evidence
Two members of staff we spoke with told us that helping the people who live in the home to make their own choices was important. They told us how they did that, for example giving them choices about what time they got up and went to bed. They told us they respected their decisions.

We saw that a copy of the complaints procedure was kept in each care plan which was kept in people's rooms so they or their relative could see it.

People's care plans showed evidence of their involvement, or that of their relative, in the planning of care. The care plans also showed a list of likes or dislikes for that person, for example types of food they enjoyed or did not like.

Our judgement
People are generally involved in making choices about their lives and are respected although there are some inconsistencies in practice.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
The people we spoke with were very complimentary about the care they received and the majority of them praised the staff. One person said the carers and nurses were "Lovely and very kind." Another said "I can't fault the home at all, the staff are very good."

The people we spoke with during our visit all said that they felt included in their care-planning process. A member of staff told us that the care plans were put together with the agreement of either the person or their relative. We saw evidence of this.

We were told by two members of staff the home had achieved the "Gold Standard Framework" for care in care homes, put together by Age UK: all people in the home were on the framework. Depending on which group people had been placed within the framework, their care was discussed by staff at different times on a regular basis and reports sent to their GP and a copy kept in their care folder. In addition to this, all people's care plans were reviewed monthly with the person or their relative.

A member of staff we spoke with said the local GP's were "quite good" in that they received a good service from them when they requested visits and we saw staff wrote in the daily notes when they had a visit from any health professional to inform other members of staff.

People were asked 24 hours in advance what they would like for their lunch the following day. We were concerned that some people with a memory loss would not be

able to remember what they had chosen. We discussed this with the matron/manager during our visit and she said she would look at the issue and resolve it.

People we spoke with said they enjoyed the food and we saw staff helping those who needed support to eat their meals. They did not rush the person.

The home had three staff employed to provide activity therapy for people living in the home and when we visited we also saw cake decorating had been arranged to take place in one of the lounges.

Other evidence
We looked at four care plans in detail and found that in the main they were complete for people's physical needs but kept in three different places. We saw that this made it harder to access information quickly when it was needed. NHS Lincolnshire, who paid for the care of some people in the home, also mentioned this when they visited on 5 January 2012. They told the home documentation should be kept in one place.

In one plan a continence assessment had not been completed in full and a number of assessments and reviews had not been dated. Other plans we looked at were not always in the same order which made them difficult to follow.

A member of staff told us that the plans were "too busy and complicated" and the matron/manager told us that she thought if agency staff went into the home "they would struggle" to follow the plans and care for people appropriately.

One person had attended the local accident and emergency department the day before our visit but nothing had been written on their discharge back to the home because the nurse on duty told us they had not had time to write in the person's daily notes.

Comprehensive life histories for people with memory problems were not available in their care plans. This meant that the staff did not always have the knowledge to care for them in a meaningful way.

When we spoke with the matron/manager, who had only been in post for three months, she acknowledged that care plans needed improving to meet their physical and psycho-social needs and make them easier to follow.

Our judgement
People received the care and support they needed to meet their physical needs. However shortfalls in the care plans, especially for those with memory loss, could lead to people's needs not being fully met.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
The people we spoke with during our visit told us they always felt very safe in the home but if they didn't they would tell a member of staff and were sure they would do something about it. One person "I feel safe and the staff are vey kind."

The staff we spoke with understood what abuse was and told us they would tell the nurse in charge or the matron/manager if they saw anybody being treated badly.

We saw the manager had needed to take action to follow up a concern raised by a relative about the care being provided to one person. We know that the action taken had ensured that the person was protected from potential harm.

Other evidence
Evidence we obtained from looking at the care being given showed that all staff treated the people in the home in a quiet, courteous and respectful way.

We also saw from training files that staff had received training in safeguarding vulnerable adults.

Our discussion with the matron/manager showed that she knew that she needed to follow the local county council's guidance on such matters. She was clear about when or if she should suspend staff that had had an allegation made against them and when she should contact the local safeguarding team.

Our judgement
People are safe and protected by robust systems and knowledgeable staff.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
Observations we made during our visit showed there were enough staff on duty to meet the needs of the people living at the home at that time.

All the people we spoke with told us they felt the staff knew their needs and how to care for them.

One person told us that "the staff are very nice and they're gentle too." Another said that "I feel the staff have the support they need to do the job properly."

The staff we spoke with during our visit told us about the training they had received and felt that it helped them to provide good care for the people living in the home.
Staff said they felt supported by the new matron/manager and that they could go and discuss any issues they had and they would be resolved.

Other evidence
When we looked at training files for staff we found that almost all the courses in the previous twelve months had been given by "in-house" trainers. In-house training means the training sessions had been given by members of staff who worked in the home. Training sessions had included those for infection control, health and safety, emergency first aid and dementia.

The matron/manager informed us most of the in-house trainers had all left and they did not know who was going to do the training in the future, especially for dementia, Mental Capacity Act and Deprivation of Liberty safeguarding. She also said she thought it

would be better if more of the training sessions were undertaken by external training providers and was going to look into this.

We saw records for "supervision" sessions that staff had received. Supervision sessions are where the staff talk with their manager on a regular basis about the work they do, any problems they have and the sort of training they need to make sure that people are well cared for. However, the records we saw were for practical supervision sessions, for example watching a member of staff do a specific task and commenting on how well they did it.

When we spoke with the matron/manager she told us she knew that documented supervision sessions had not been occurring and she was going to commence them as soon as she could

Staff told us they had received appraisals and we saw evidence that these had occurred annually in the past for the majority of staff.

Our judgement
Staff benefited from a manager who supported them and they had attended training sessions in order to promote people's health and welfare. However, thay had not received regular and documented supervision.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
The people we spoke with said they were happy with their rooms and the general facilities the home provided. During our tour of the home we saw it was clean and tidy with no unpleasant odours.

No-one raised any concerns or complaints during our visit but they said they would feel comfortable speaking to the manager or staff if anything arose. One person commented "I can't fault the home at all, I like everything." Another person told us "I'm fairly well looked after one way or another."

When we asked people if they had been asked for their opinions of the home, one person told us "I've been asked a time or two" but could not remember when.

Another person we spoke with who had been in the home for three months said they hadn't been asked of they liked it yet and then added "I wouldn't want to change anything anyway."

We were told the home held resident's council meetings and we saw the minutes for the previous one held in January 2012. There were no concerns raised at the meeting.

Two staff members we spoke with informed us that staff meetings were held as and when they were necessary, the last one had been held at the beginning of February 2012. Minutes of the meeting were available for us to see and we saw there were no concerns or issues raised. The matron/manager told us that she intended to hold these

every three months. We were also told by a member of staff that the matron/manager listened to them if they had worries or concerns.

Other evidence
We saw copies of a questionnaire that had been distributed to the people in the home but there was no date on the documents and no report available about the results.

There was evidence of audits undertaken for care-plans, infection prevention and control, housekeeping and the kitchen, all dating back to August 2011. There had been no audits since.

We also saw copies of recent reports from the environmental health department and a local chemist relating to the storage and administration of drugs; no major issues had been raised.

The matron/manager told us she was aware that a more complex and regular system of auditing was needed in the home and was in the process of introducing this.

Our judgement
The monitoring of quality in the service was not robust enough to ensure that risks to people's health, welfare and safety were identified and reduced.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People received the care and support they needed to meet their physical needs. However shortfalls in the care plans, especially for those with memory loss, could lead to people's needs not being fully met.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People received the care and support they needed to meet their physical needs. However shortfalls in the care plans, especially for those with memory loss, could lead to people's needs not being fully met.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People received the care and support they needed to meet their physical needs. However shortfalls in the care plans, especially for those with memory loss, could lead to people's needs not being fully met.	
Accommodation for persons who require nursing or personal care	Regulation 23	Outcome 14:

	HSCA 2008 (Regulated Activities) Regulations 2010	Supporting staff
	How the regulation is not being met: Staff benefited from a manager who supported them and they had attended training sessions in order to promote people's health and welfare. However, thay had not received regular and documented supervision.	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff benefited from a manager who supported them and they had attended training sessions in order to promote people's health and welfare. However, thay had not received regular and documented supervision.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff benefited from a manager who supported them and they had attended training sessions in order to promote people's health and welfare. However, thay had not received regular and documented supervision.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The monitoring of quality in the service was not robust enough to ensure that risks to people's health, welfare and safety were	

	identified and reduced.	
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The monitoring of quality in the service was not robust enough to ensure that risks to people's health, welfare and safety were identified and reduced.	
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The monitoring of quality in the service was not robust enough to ensure that risks to people's health, welfare and safety were identified and reduced.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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