High Quality Lifestyles Limited

St. Michaels

Inspection report

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Date of inspection visit:
09 October 2018
10 October 2018

Date of publication:
11 January 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 and 10 October 2018. The inspection was unannounced.

St Michaels is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St. Michaels is a service for five people who have autism and learning disabilities. It is a specialist service for people that have anxious or emotional behaviour that has limited their quality of life and experiences. Each person lives in their own flat or a bungalow and the staff team and service provided is organised around their individual needs. There is an office building where the management team are based and large garden areas, including secluded areas and fenced areas for people who need more security. The service is comprised of four flats located in one building, together with a purpose built bungalow with enclosed garden area within the grounds. At the time of the inspection, there were four people using the service.

The care service has been developed and designed in line with the values that underpin the 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The service had a registered manager, however, although still registered at the time of our inspection, the registered manager had not been in post since July 2018. A peripatetic manager oversaw the day to day running of the service while the provider was in the process of recruiting a new 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 requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

St Michaels was last inspected on 26 and 27 April 2016. At that inspection the service was rated as Good overall and in each domain, with the exception of the Responsive domain, which was rated as outstanding.

At this inspection, the service had declined. There were not always enough staff to safely support people or consider potential risks to staff. Insufficient priority had been given to some repairs which potentially presented a risk of harm. Water safety management checks were not completed in line with policy or guidance and some cleaning tasks intended to reduce the risk of waterborne infection were not completed. Although most equipment had been serviced and inspected, the safety inspection of a large gas appliance in the basement of the main building had not been completed. There were appropriate processes in place for ordering, administration and storage of medicines. However, records of medicines staff took with them when they accompanied people in settings outside of the service were not always completed.

Some training, including safeguarding training, had not always been completed within timescale. Consequently, a safeguarding matter emerged during the inspection because of how a person told us a member of staff had spoken to them. People were not safeguarded from situations in which they may experience abuse. In addition, supervision meetings with staff had not always taken place when planned which, if completed, may have highlighted overdue training. Management of the service had failed to fully address some of these issues to ensure compliance.

The registered and peripatetic managers had quality audits in place. However, this was not comprehensive enough to enable the service to assess, monitor and improve quality and safety service. The service management were not aware of some of the concerns found during this inspection.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider and staff understood their responsibilities under the Mental Capacity Act 2005.

Pre-assessments for people moving to the service were comprehensive. Potential risks to people's health and welfare were identified. Each person had an up to date, personalised support plan, which set out how their care and support needs should be met by staff. These were reviewed regularly. People received the support they needed to access healthcare services and were supported to eat and drink enough to meet their needs. Staff ensured people's privacy was maintained when supporting with their personal care.

People were, as far as possible, supported to have choice and control of their lives and staff supported them in the least restrictive way. The policies and systems in the service supported this practice. Staff encouraged people to participate in activities, pursue their interests and to maintain relationships with people important to them. Relatives and visitors were welcomed at the service and a complaints procedure was available and in an accessible format if people wished to make a complaint.
Accidents and incidents were analysed and measures were in place to reduce the occurrence of repeated incidents. Referrals were made to specialist services and medical professionals when needed.

Services providing health and social care to people are required to inform CQC of important events that happen in the service, this is so checks can be made that appropriate action had been taken. The manager was aware that they needed to inform CQC of important events in a timely manner and had done so.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the services can be informed of our judgements. The provider had conspicuously displayed the rating in the reception area of the service and a link on their website to the latest CQC report.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always sufficient staff on duty to meet people's needs or mitigate against risk.

People were not always protected from the risk of harm or abuse.

Some equipment and furnishings were not always maintained to a safe standard.

Medicines were mostly managed safely, however, some supplementary records were not always maintained.

There was a robust recruitment process in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Training had not been effectively managed or delivered for all staff.

Supervision meetings for staff had previously lapsed, but plans were now in place and this was being addressed.

People's health was monitored and staff ensured people had access to external healthcare professionals when they needed it.

People's rights had been protected by proper use of the Mental Capacity Act (MCA) 2005.

People received enough to eat and drink and were complimentary about the quality of food provided.

Is the service caring?

Requires Improvement

The service not was consistently caring.

Some staff practice did not always reflect the values and behaviours of a caring service.

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

People were enabled and supported to maintain relationships with families and friends.

Private information was kept confidential.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staffing voids meant people's support needs were not always met.

The service involved people and their families or advocates in planning and reviewing care.

Care plans were individual, and person centred and reflected people's choices.

There was a variety of activities, functions and outings on offer.

An accessible complaints procedure was in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assessment audits were in place. However, they were not comprehensive enough to enable adequate monitoring or improve the quality and safety of the service.

The service had an open and approachable management team. Staff were supported to work in a transparent and supportive culture.

Both management and staff understood their roles and responsibilities.

Care Quality Commission

St. Michaels

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 in response to concerns received to check whether the provider was 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.

We used information sent to us in the last Provider Information Return to help plan this inspection. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

We visited the service on 9 and 10 October 2018 and the inspection was unannounced. St Michaels was a smaller service and, therefore, the inspection was carried out by one inspector to ensure it was the least intrusive as possible for the people living there.

We met three people who lived at the service and spoke with two of them, we observed some people's care, some medicine administration and some activities. We inspected the environment, including the laundry area and some people's individual self-contained accommodation. We spoke with three care staff, including a senior carer as well as the deputy manager, peripatetic manager, the Positive Behaviour Support practitioner, a newly appointed quality assurance lead and the senior improvement quality lead.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us.

During the inspection we reviewed other records. These included staff training and supervision records, five staff recruitment records, medicine records, care plans for three people, risk assessments, accidents and incident records, quality audits and policies and procedures.

Following the inspection, we invited and received feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service as well as the local authority. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes. We received two responses.

Requires Improvement

Is the service safe?

Our findings

People told us or were able to indicate that they felt safe. One person told us, "I am well supported and feel secure in my flat." Another person showed us they were happy with a hand signal. We observed other people's responses to staff supporting them; they were content, interacted with staff and were able to communicate their needs, which staff understood and responded to. However, areas were identified where the service was not safe.

There were not always enough staff on duty. A needs assessment tool was in place and staffing requirements were assessed against people's needs and risks. However, information received indicated there were not always sufficient staff on duty. We reviewed the needs assessment tool and were satisfied that, when staffed as assessed, people's requirements could be met for each shift. However, discussion with staff, the peripatetic manager and a review of the staff rota found there were not always enough staff on duty.

Assessed risks to assure people's safety and, potentially, the safety of staff were not always mitigated. Detailed risk assessments set out the staffing requirements needed to keep people safe within the service and in public. This was intended to ensure people would be adequately supported if their behaviour became challenging toward others, staff or self-injurious. Two people needed continuous two to one support within the service, rising to three to one support outside of the service. The remaining people needed continuous one to one support within the service, rising to two to one support in the community. Staffing did not meet this requirement for an afternoon shift on the Sunday immediately before this inspection; a minimum of six staff were needed but only five staff were on duty. Furthermore, a review of safeguarding referrals found a previous incident where staff did not attend for the full duration of their shift, leaving people without the support assessed as needed. While managers were aware of these incidents, efforts were not successful to secure the staffing numbers needed on these occasions. In addition, discussion found there was no standard operating procedure to guide staff or managers about what to do if the number of staff fell below that required.

The provider had not ensured there were sufficient numbers of staff deployed to meet the assessed requirements. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of abuse. During the inspection, discussion with one person found a staff member had threatened to cancel a prearranged outing in response to their anxious behaviour. The person told us they felt more anxious, threatened and disappointed. Safeguarding is intended to protect people from circumstances they may find emotionally, physically or financially hurtful. Staff had not acted appropriately. Discussion with the peripatetic manager found the member of staff had not completed the required safeguarding training. A referral was made to the local authority safeguarding team about this incident during the inspection. Safeguarding training had been completed by other staff, they were able to tell us about different forms of abuse. Staff understood their responsibilities in reporting any concerns. Policies and procedures were in place for whistleblowing, as well as policies in relation to

bullying and harassment. Safeguarding matters were investigated and reported to the safeguarding authorities as necessary.

The provider had not ensured people were protected from psychological abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked in people's flats, the self-contained bungalow and at the general condition of the fittings, furniture, maintenance of the service and appliances. While decoration had kept pace with the rate of wear, not enough priority was attached to replacement of a bath. A hole had rusted around the external lip of the bath next to the built-in handhold. The edges of the hole were jagged, large enough to place a finger in and potentially cut bare skin if a person caught themselves on it getting in or out of the bath. While we saw the bath was reported as requiring replacement and records showed contractors were appointed, no action was taken to make the bath safe in the meantime. We pointed this out during the inspection and a smooth plastic cover was bonded over the rusted hole and made safe. No explanation was offered why this could not have happened when the hole was first noticed on 18 September 2018.

Additionally, the internal foam cushioning of a damaged chair presented a potential choking hazard. This was because the person who used the chair had known behaviour of placing inedible objects in their mouth. Looking at the chair, it was evident pieces of foam had been picked out, they were not on the floor or around the chair. Given the known behaviour of the person and potential choking risk from the foam, action should have been taken to remove the chair from the person's room. As soon as this risk was pointed out, the chair was removed.

Current gas safety certificates were held for most appliances used at the service. However, the gas fired tumble drier, located in the basement of the same building as the four flats, had not been inspected since August 2016. In such settings, annual safety checks and servicing in accordance with manufacture's recommendations are required. This had not happened; therefore, the service could not be sure the drier was operating correctly, or that any carbon monoxide combustion fumes were safely ducted out of the building. Maintenance scheduling did not include service and safety checks for the drier as they had not been identified as required. In addition, water temperature checks did not comply with the service's policy to ensure water was circulated at an appropriate temperature, or that shower heads were regularly cleaned and descaled to reduce the risk of legionella, a waterborne bacterium. Similarly, maintenance scheduling and checks did not identify that such checks were required and missing.

Some people experienced epileptic seizures and needed staff to carry rescue medicines when they accompanied people outside of the service. Although there was an established process and recording method to book these medicines in and out of the service, we found this had lapsed and was not completed by all staff. Therefore, there was no record people had access to required medicines when outside of the home. This did not contribute to the proper and safe use of medicines.

The provider had not ensured the premises were safe to use for their intended purpose, that the equipment used for providing care or treatment was safe or the proper and safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Otherwise, records of medicines were complete. People received their medicines when they needed them, staff had received appropriate training and competency supervision. There were clear protocols in place to make sure people received the right amount of medicines safely and on time. Staff were aware of people's conditions and the medicines they received. All medicines were stored securely in line with current

guidance. Appropriate arrangements were in place for ordering, recording, administering and disposing of prescribed medicines by staff who had received training and who had been assessed as competent to do so. Clear records were kept of all medicine that had been administered within the service. The records were up to date and had no gaps, showing all medicines administered had been signed for. Well established links with healthcare professionals ensured clear communication and guidance for staff of any changes to medicines, or the need for medicine reviews and when these were undertaken. Guidance was in place for people who took medicines prescribed 'as and when required' (PRN). Regular medicine audits were carried out by the registered manager or key staff. This helped to ensure people received all their medicines safely. Application of prescribed creams were recorded separately and completed.

Risks to people were identified, risk assessments were detailed and regularly reviewed. Function assessments for some people gave insight into possible behavioural responses. A function assessment focuses on the why, how, where, when and what a person's behaviour. These helped to formulate strategies for staff to positively support people when these events occurred and to structure people's support, avoiding potential behavioural triggers. Staff were aware of the risk assessments for each person and had signed each one to say they had read and understood them. Staff spoke knowledgably about how to support each person and minimise risk to them. Some behaviour could present risk to others, staff and the person themselves. All staff were trained in PROAC- SCIP (Positive Range of Options to Avoid Crisis and use Therapy – Strategies for Crisis Intervention Prevention) skills to use a least restrictive approach. This focusses on an approach to support, which promotes prevention (proactive and reactive) rather than intervention.

However, on occasion, to keep people safe, intervention restraint was used. The restraint used was carefully considered and only authorised for crisis management. Other options, such as staff withdrawing to give people space, were used when possible. Each restraint was fully recorded, together with structured observations to ensure people's safety and recovery. Every event was analysed in detail with any learning points, such as triggers, noted and incorporated into risk assessment reviews. The service kept extensive records of intervention events. These were shared with healthcare and behavioural specialists to ensure they were warranted and provide a detailed overview of people's progress and support needs. Accidents or incidents had been appropriately recorded. They were investigated at service level and overseen at provider level. Appropriate action was taken when accidents and incidents had occurred. Information was used to review risk assessments and inform any points of learning to reduce the possibility of reoccurrence.

Safe recruitment procedures were in place. Staff recruitment records viewed showed all of the relevant checks had been completed before staff began work. These included disclosure and barring service (DBS) checks, evidence of conduct in previous employment and proof of identity. Staff were not allowed to start work until these checks had been completed. Staff confirmed there was a robust interview process in place. This helped to ensure that staff employed by the service were suitable to work with the people they cared for.

The service was clean and free from odour, effective cleaning schedules set out appropriate levels and methods for cleaning of the premises and most equipment. Procedures were in place for reporting repairs and records were kept of maintenance jobs, most were completed promptly after they had been reported. Records showed portable electrical appliances and firefighting equipment were properly maintained and tested. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order. Records showed Health and Safety audits were completed monthly and that these were reviewed by management to see if any action was required. Fire risks had been thoroughly assessed and people had individual emergency evacuation plans. These gave details of the assistance each person needed in an urgent situation. Staff had regular fire safety training and could describe the way in which

people would be helped. Evaluation of fire drills helped ensure any areas of improvement were recognised and addressed.

Policies and procedures on all health and safety related topics were held in a file in the office and were easily accessible to all staff. Staff told us they knew where to find the policies.

Requires Improvement

Is the service effective?

Our findings

People told us staff looked after them well. One person said, "I feel I have always been given the support I need". Another indicated with their hand they were happy with the support provided.

There was a schedule of training in place. Training was delivered as a mixture of e-learning and face to face training, with refresher training booked in advance when needed. Training in all mandatory subjects was up to date for most staff. However, we discussed with the peripatetic manager a safeguarding concern received during the inspection. Training records showed while the member of staff concerned had received some induction training around safeguarding, they had not completed the e-learning course or received face to face training. Records confirmed the safeguarding e learning training should have been completed by July 2018. No explanation was offered as to why the training had not been completed. Training had not been effectively managed or delivered for all staff.

The provider had not ensured staff were suitably qualified or competent because persons employed by the service provider had not received appropriate training as is necessary to enable them to carry out the duties they are employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A schedule of supervision and appraisal set out when these meetings should take place. We saw some supervisions had previously lapsed, however, arrangements were now in hand to address this and dates had been booked for the meetings to take place. Nevertheless, this is an area identified as requiring improvement.

Staff had undertaken training in subjects key to the support needs of people, such as epilepsy, autism awareness and challenging behaviour (PROAC-SCIP). Competency checks were completed after training sessions to check staff knowledge and understanding. Staff told us the training was a good standard in a range of subjects which enabled them to perform their roles safely and to provide the right care and support to meet people's needs.

Staff told us they had an induction when they started work at the service, this involved time reading people's care records, policies and procedures and getting to know the service and emergency procedures. They then spent several weeks shadowing experienced colleagues to get to know people, their individual routines and for people to become familiar with the staff. New staff had received a comprehensive programme of training before working with people and, additionally, were paired with experienced existing staff.

All staff, who were new to care working, were completing the Care Certificate. This is a set of standards for social care workers to follow in their daily working lives. Processes were in place for new staff to be supported through their induction, monitored and assessed to check they had the right skills and knowledge. Staff received support during formal one to one meetings with managers; some meetings were planned in advance, while others were in response to situations arising. Staff discussed issues that had happened in the service and reflected on their practice.

People were supported and encouraged to eat a healthy and nutritious diet. One person told us, "The food is really very good." Picture cards with a bold print description were used to help some people choose what they wanted to eat, other people were more able to communicate their choices. Most people, with staff supervision, helped with to prepare their meals in kitchens located in their flat or bungalow. Where needed, people received support and supervision to eat to minimise any risk of choking. Advice received from dieticians and speech and language therapists to help some people eat safely was put into practice. Kitchen areas and fridges were clean and stored food was in date. Meal times were well organised and not rushed. Where concerns were identified around how much people ate or drank, records were made. This enabled staff to track how much people ate and formed a starting point for GP's or dieticians to decide if action was required.

People's mental capacity to make day to day decisions had been considered and there was information about this in their care plans. The management and staff had knowledge of and had completed training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff showed good knowledge and understanding of the MCA. We observed staff offering people choices and they told us about people who needed more help to make their own decisions. For example, to make day to day choices about what they wanted to do, eat and wear. If a person was unable to make a decision about medical treatment, dental procedure or any other big decisions, then relatives, health professionals and social services representatives were involved to make sure decisions were made in the person's best interest.

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 so that they can receive care and treatment when it 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).

At this inspection we checked whether the service was working within the principles of the MCA. Applications had been made for DoLS authorisations for people who needed them, and authorisations received. The service was responsible for making applications and the relevant supervisory body (local authority) considered each application, issuing authorisations as needed. This ensured any restrictions on people's liberty were warranted and the least restrictive as possible. Any conditions attached to the authorisations were met.

People's needs were carefully assessed prior to them moving into the service. This enabled managers to consider if the service could meet people's needs and review if any additional staffing or training was required. Resulting care plans were developed in line with good practice, including guidance provided by the National Institute of Health and Care Excellence (NICE), NHS guidance and the principles of person centred planning.

People's health was monitored to help maintain their well-being. People had regular access to speech and language therapists, occupational health practitioners, opticians, chiropodists and GPs to assess people and contribute to their care and support. Records of day to day care showed staff were able to quickly notice any changes in people's health and condition. This helped to ensure any healthcare needs or referrals were made in a timely way. People's weight was well managed, no concerns were identified and there were examples where one person was supported to lose weight. Where possible, people and their relatives were involved in planning care delivery and were aware of risks to be monitored and managed. People had health care passports, these provided key information about them if, for example, they needed to go to hospital.

The flats and bungalow had been adapted to meet the specific needs of individuals. Living accommodation was carefully planned and furnished to suit people's needs, preference and tolerance. For example, some living areas appeared sparsely furnished with few pictures. This was by design as some people experienced overstimulation is richly furnished or decorated surroundings. Furniture in some people's rooms was robustly constructed, weighted or upholstered in tear resistant fabric to ensure is kept pace with the rate of use and presented as low risk as possible to people. Gardens were well kept and accessible to people, some parts of the garden were enclosed in high anti-climb fencing. This gave people the freedom to use garden while remaining safe.

Requires Improvement

Is the service caring?

Our findings

People told us, and records showed relatives were involved in discussing support needs with staff, so care was tailored to people's personal preferences. Relatives had been sent copies of care plans and any comments received were incorporated into the provision of care. Staff offered choices and explained to people what they were doing while supporting them. Care and support was given in response and in the way people wanted it.

However, providers are expected to be caring in the way they provide resources including providing person centred care. Voids in staffing, caused by the service provider not having standard operating procedures to successfully fill short notice absences, meant some peoples' support needs were not always met. Additionally, some staff not completing their full shifts, again leaving people with unmet support needs, did not demonstrate the values and behaviours of a caring service. Therefore, this is an area identified as requiring improvement.

Otherwise, during the inspection we saw, there were caring and trusting relationships between people and staff. Staff appeared genuinely fond of the people they supported and were keen to improve their lives in any way possible. For example, encouraging one person to attend college and supporting them to complete a CV and sensitively managing their expectations about interview processes and work possibilities. Another person had recently started to go swimming.

People were happy to interact with staff and guide them towards what they did and didn't want to do. Staff were aware of people's individual communication needs and understood the meaning of different words and phrases people used. People were helped to develop meaningful communication through signs, gestures, objects, pictures and writing, including some that people had uniquely developed as their own. Some people had learnt particular communication systems as children, such as Makaton and staff were aware of these and developed them further. Other people enjoyed technology, so this was also included as means of communication. Staff also looked for and recorded different signs that may signal communication. Staff were able to identify quickly if people were in pain or discomfort, by looking at body position, posture, facial expression and behaviour for people who were unable to otherwise communicate these needs. People were treated individualy and equally; diversity was embraced, and people were treated warmly and with respect.

Staff knew people well and about their backgrounds and could speak with them about their lives, people and events that were important to them. Some people were able to tell us staff supported them in the way they preferred, and this enabled them to be as independent as possible. People were supported to move around the service and their accommodation independently as possible. Staff were patient with people, recognising when to provide support and when to step back to enable independence, or allow people space and time to process what was going on around them or how they were feeling. Staff respected people's homes and their right to do things for themselves.

People were supported to make decisions about their care and make choices about their lifestyle. Some

people had family members to support them when they needed to make complex decisions, such as coming to live at the service or to attend health care appointments. Some people were unable to express their views about their care, so staff ensured decisions were made by involving people who were important to them, including their family. If needed, staff knew how to refer to advocacy services when people needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

People told us they could speak with relatives, have visitors and meet with health and social care professionals in private if they wished to. Staff assisted some people to keep in touch with their relatives by Skype, telephone and meeting some travel expenses to facilitate visits of some people's family members.

The provider was aware of the General Data Protection Regulation (GDPR) which came into effect in May 2018. GDPR was designed to ensure privacy laws were in place to protect and change the way organisations approach data privacy. Suitable arrangements were made to ensure private information was kept confidential. Written records containing private information were stored securely when not in use. Computer records were password protected and only available to those with a right to see them. Staff and review meetings, where people's personal information was discussed, were held in private.

Requires Improvement

Is the service responsive?

Our findings

The service was not consistently responsive because staff resource voids meant some people did not have the support they were assessed as always needing. Additionally, on one occasion, people would have been unable to leave the service to take part in any activities because insufficient staff were on site to support people safely. For some people, routine and expectation was very important because unplanned changes could cause anxiety and act as behavioural triggers. Despite best efforts, staffing issues had impacted on people's daily routines and people had not received a consistent service. This is an area identified as requiring improvement.

Each person had a pre-admission assessment to ensure that the service would be able to meet their individual needs. The assessment included consideration of the current resident group and how the potential new person would adapt to living in the service, with the people already there. If there was any doubt the service may not be able to meet a person's needs or the impact of them moving in would be detrimental to other people, the placement was not offered. Admission assessments and resulting care plans captured an inclusive approach to care and included the support people required for their physical, emotional and social well-being in addition to communication needs, behaviours that could challenge. This included an awareness at of how to support people to maintain their any choices around their religion or diversity. The assessments included all aspects of care and formed the basis for care planning after people moved to the service.

People's care plans were person centred and contained specific, detailed guidance for staff to follow, meaning they would be able to support each person in the way they preferred. There were life histories, detailed guidance on communication and personal risk assessments. In addition, there was specific guidance describing how the staff should support the person with various needs, including what they can do for themselves, what they need help with and how to support them. Information about people's wishes and preferences was recorded and detailed guidance on people's likes and dislikes around food, drinks, activities and situations. Nobody was receiving end of life care. Care plans included information from people and their families about how people wanted this to be provided.

Challenging behaviour care plans detailed what people may do, why they do it, warning signs and triggers and how best to support them. Care plans were well developed and focused upon people's choices and preferences. People had been involved in their care planning and some had signed their care plans in agreement of their content. Where people had particular healthcare needs; such as diabetes or epilepsy, staff were able to confidently tell us about their conditions and the support people needed. People had review meetings to discuss their care and support. They invited care managers, family and staff. Staff had developed positive relationships with people and their friends and families. Staff kept relatives up to date with any changes in people's needs. People felt the care and support delivered at the service was suited to their individual needs.

Care plans were comprehensive and had been reviewed monthly or as required and were up to date, they reflected the care and support given to people during the inspection. People had the opportunity to be

involved in the assessment and review of their needs and preferences as much or as little as they wanted to be. This helped to ensure care and support was tailored to meet their needs. Staff spent time with people to find out how they liked to be supported and this was reviewed and changed in response to people's changing needs and developing skills and abilities. People's care and support was set out in a visual and written plan in the way that suited people best. Care plans reflected the care and support given to people during the inspection.

Some people had experienced breakdowns in their previous care arrangements. The support people received from staff was tailored to individual needs; staff had got to know people well and understand what was important to them. People had opportunities to live fulfilled and meaningful lives despite some very challenging and complex needs. Goals and aspirations were individual, clear and regularly reviewed. Most involved activities outside the service, including swimming, social clubs, theme parks, going to the cinema, eating out and drinks at the pub. Some of the activities were to try out new experiences and a way to experience new things and develop daily living skills. For example, one person had enjoyed a rollercoaster ride and another person was looking forward to going to the Comic Con exhibition.

From 1 August 2016, providers of publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. Information was available to people in a way that met their needs in line with the Act. Communication was part of the individual assessment tool completed for each person. Any needs identified to facilitate communication were recorded and responded to.

An established complaint recording system was in place, so complaints could be logged and document when acknowledgments and final responses were sent. The provider's complaints policy was displayed in the office, giving guidance about how to make a complaint if necessary. Records showed to complaints as received since the last inspection, they had been recorded and processed in line with policy and both remained ongoing.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well led. Staff had not been held accountable for their responsibilities and effective management checks had not been completed to monitor, maintain or improve the quality of the service.

At our last inspection in April 2106, a registered manager was in post who was solely responsible for the day to day running of St Michaels. In June 2017 this registered manager left the service. Although further registered managers were since appointed, they were also responsible for the day to day running of other services operated by the same provider. This had had an impact on the day to day running of St Michaels. At this inspection, final stage interviews were in progress for a new manager of this service. Discussion with senior management confirmed, when in post, the new manager would be solely responsible for St Michaels and would not also be responsible for day to day running of any other services. In the interim, management of the service was delegated to peripatetic managers, again solely responsible for St Michaels.

At this inspection we found, there had been insufficient oversight to maintain or improve the quality of the service. Audits were not wholly effective; some had identified issues but had failed to address immediate concerns. For example, in relation to the rusted jagged hole on the outer edge of the bath. Other audits, or day to day checks of the service had failed to identify potential dangers or rectify them. For example, in relation to damaged furniture allowing a person to pick out the internal foam, potentially creating a choking hazard. Other checks had failed to identify a gas appliance had not received an annual safety check since 2016. Although now back on track, lapses in staff supervisions and oversight of training did not identify incomplete mandatory training for a member of staff and therefore recognise the risk of safeguarding issues. This had resulted in a lack of accountability for some staff and manifested other concerns in relation to short notice absence, incomplete shifts and resulting staffing voids. In addition, there was no standard operating procedure in place to ensure sufficient staff would be on duty at the service if staff, due at the next shift, did not arrive as expected. Although every effort was made to incentivise staff to cover the voids and agencies were approached, this had not mitigated risk and had directly impacted on the support provided to people, potentially placing them and staff at risk of harm.

The failure to operate effective quality monitoring systems was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a range of policies and procedures governing how the service needed to be run. The peripatetic manager followed these in reporting incidents and events internally and to outside agencies. The peripatetic manager kept staff up to date with current developments in social care. Communication within the service was facilitated through meetings. There were staff handovers after every shift, regular staff meetings and regular management meetings. There were also meetings with the management team and with the provider. At these meetings, any concerns, actions or issues were discussed and addressed. All the services' policies and procedures were regularly reviewed and updated.

There was an emerging positive and open culture between people, staff and management. Through our

observations and discussion with some staff, it was clear that there was a good team work ethic amongst those spoken with, and staff felt committed to providing a good quality of life to people. All staff we spoke to told us they were clear about their roles and who they were accountable to. They felt they all worked well as a team and told us they felt proud of the work they did and of the service and positive difference they made to people's lives. Throughout the inspection, the peripatetic manager and staff were open to different ideas we discussed. Their responses showed they were keen to develop and improve the service, so they could meet people's needs safely and effectively.

The peripatetic manager worked proactively to keep staff informed on equality and diversity issues. They had discussed wellbeing, equality and diversity with staff and training had taken place to ensure staff were sufficiently informed to uphold the diversity values expected of them.

The peripatetic manager understood their regulatory responsibilities. Services that provide health and social care to people are required to inform CQC of events that happen, such as a serious accident, so CQC can check that appropriate action was taken to prevent people from further harm. The registered or peripatetic manager notified CQC and the local authority in a timely manner.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The most recent CQC report was displayed in the service and a link to the latest report was on the provider's website in line with guidance.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way for service users; areas of the premises and some equipment was not safely maintained; incomplete records did not assure the proper and safe management of medicines; Reg 12 (2)(d)(e)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure service users were protected from abuse and improper treatment. Reg 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure processes were established and operated effectively to assess, monitor and improve the quality and safety of the services provided; assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; maintain accurate, complete and contemporaneous record in respect of each service user.

	Reg 17 (1)(2) (a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed in order to meet people's needs; some staff had not received appropriate support. Reg 18 (1)(2)(a)