Leonard Cheshire Disability

St Michael's - Care Home with Nursing Physical Disabilities

Inspection report

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Date of inspection visit:
31 July 2023
01 August 2023

Date of publication:
29 September 2023

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
St Michael's - Care Home with Nursing Physical Disabilities is a nursing home providing personal and nursing care for up to 36 people. The service provides support to people with complex neurological and physical disabilities. At the time of our inspection, there were 20 people using the service. The building is a large period building with a sizeable communal dining area. There is a physiotherapy room on site.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and/or who are autistic.

People's experience of using this service and what we found.
Right Support, Right Care and Right Culture
The provider did not always have oversight of the service; there were inconsistencies in the recording of people's information, which meant people were not always getting good quality and safe care. There was mixed feedback from staff about how safe they felt the service was. Staff training had improved since our last inspection; although there were still concerns with how well people were cared for, there was a plan in place for nursing staff to have their competencies reviewed. We observed positive interactions between staff and people.

For more details, please see the full report, which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was inadequate (published 06 June 2022). A targeted inspection took place on 20 June, the service was not rated from that inspection.

Why we inspected
We undertook this targeted inspection to check whether the Warning Notices we previously served in relation to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. The overall rating for the service has not changed following this targeted inspection and remains Inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Enforcement and Recommendations
We have identified continued breaches in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good Governance)

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will follow our enforcement procedures.

Special Measures
The overall rating for this service remains 'Inadequate', and the service remains in 'special measures'. This means we will keep the service under review, and if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it, and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not Safe Details are in our Safe findings below	**Inspected but not rated**
Is the service well-led? The service was not Well Led Details are in our Well Led findings below	**Inspected but not rated**

St Michael's - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

This was a targeted inspection to check whether the provider had met the requirements of the Warning Notice in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
St Michael's - Care Home with Nursing Physical Disabilities is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. St Michael's - Care Home with Nursing Physical Disabilities is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage

the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and for compliance with regulations.

At the time of our inspection, there was a registered manager in post; however, they were not present during the inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from partner agencies and professionals.

During the inspection
We spoke with 8 staff during the inspections, including the interim manager. We reviewed 5 care plans, risk assessments, governance and auditing documents and other documents relating to the safety of people living at the service.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection, this key question was rated Inadequate. We have not changed the rating as we have not looked at all of the safe key questions at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

At the focused inspection conducted in March 2023, we identified the provider had failed to ensure that risks to people were mitigated. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A warning notice was issued in relation to this.

At this inspection, not enough improvement had been made, and the provider was still in breach of Regulation 12.

Assessing risk, safety monitoring and management

- During the inspection in March 2023, we identified concerns with the care of people who were fed through Percutaneous Endoscopic Gastrostomy (PEG). PEG is when people have a feeding tube through the abdominal wall and into the stomach. It allows nutrition, fluids and/or medicines to directly reach the stomach. Although some improvements had been made in the management of risks to people who were PEG fed, there were still some discrepancies in the way information was recorded and shared with staff.
- For example, the electronic medicines system prompted staff to monitor the position people were in when receiving their PEG feed in order to reduce the risk of complications. However, instructions in place did not specify the position people needed to be in. This placed people at risk.
- In addition, records did not show that people consistently received their PEG feeds on time. For example, 1 person was prescribed a PEG feed from 20.00hrs to 06.00 hrs. Records showed that on 6 occasions in a 10 day period, the feed regime was started at least 2 hours late.
- At the last inspection, we identified concerns around diabetes management and staff not receiving relevant training to support people who had diabetes. Whilst improvements had been made to ensure staff had the right knowledge and skills to meet the needs of people, we still found shortfalls. Information within care plans in relation to people's health needs, such as diabetes, was limited.
- There was no documented guidance for staff on how to recognise the signs and symptoms of low or high blood sugar or the steps they should take if this happened. However, during a discussion with staff, they confirmed they had attended diabetes training and were able to inform us of the signs and actions that would be taken.
- Staff gave mixed feedback about how safe the service was. Comments included, "We do have a level of settlement here; it's a bit better. There is a better level of seeking support; staff will call if they need advice and they know they will be supported", "I'm confident everybody is safe here; we are trying our best" and, "No, it doesn't feel safe, but we've [staff] stayed for the residents, I do speak up, because I don't feel it's safe."

This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the interim manager introduced regular meetings with staff about risks associated with diabetes and diabetes management.

Using medicines safely

● During the last inspection, we found that medicines were not managed safely. At this inspection, medicines continued not to be managed safely.

● At the focused inspection in March 2023 there were issues in relation to poor stock management, and the service told us they were meeting with the local pharmacy to address these. At this inspection, although there had been some improvements, people did not always receive their medicines as prescribed. For example, 1 person had been given 1 of their medicines at 14.00 hours on 30 July. They had missed 2 subsequent doses because there was none in stock. Records showed staff had carried out a stock check of this person's medicines on 28 July 2023, but there was no record of staff ordering more medicine to prevent the person not receiving them on time.

● Regular medicine stock checks had recently been put in place by the interim management team to prevent missed medicines. A staff member said the new checks were "A bit effective, but not completely effective."

● At the focused inspection in March 2023, transdermal patch record recording was highlighted as an issue. Staff were not routinely recording where they had applied patches, which meant they could not be sure they were following the manufacturer's administration guidance. At this inspection, patch records were in place, but they did not show that staff rotated patch placement in line with the manufacturer's guidance.

● In addition, since the last inspection, the interim manager had recently raised a safeguarding in relation to a person being given a transdermal patch that was not prescribed for them.

● Controlled medicines were not managed safely. When administering controlled medicines, a second person should witness the medicine being administered and should sign to confirm this. The controlled drug register showed that this did not always happen, and that staff were administering controlled medicines unwitnessed. We saw gaps in the controlled medicine log book, and a staff member told us it was not uncommon for a drug to be administered without a witness and that another nurse or medicines trained member of staff would sign the following day. The interim manager had put in place a document for staff to sign to confirm they understood their responsibilities when acting as a witness in this situation.

● At the focused inspection in March 2023, we noted that protocols for medicines people might occasionally require (PRN) were not always personalised. At this inspection, we found this remained unchanged. Protocols did not always provide enough information for staff on when and why people might require additional medicines or if there were alternative actions to be taken before resorting to the use of medicines.

● When PRN medicines were administered, staff had not always documented clearly why they had been required. For example, we looked at administration records for 1 person who had been given pain relief over 3 days. Staff had documented "General pain" and, for the outcome, "Ongoing monitoring." This meant it would be difficult to assess if people needed a medicines review with the GP and also made it difficult to assess how effective people's medicines were.

This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We raised our concerns with the interim manager during the inspection process. They took immediate action to address our concerns identified with medicines.

● At the focused inspection in March 2023, we noted issues in relation to stock management of homely remedies. At this inspection, we saw that homely remedies were no longer in use.
● At the focused inspection in March 2023, people did not have regular medicine reviews. The interim management team had implemented regular medicine reviews and these had begun.
● Weekly and monthly medicine audits were now carried out.
● Staff administering medicines had been trained to do so. The interim management team told us they were currently reviewing staff competencies.

Preventing and controlling infection
● At the focused inspection in March 2023, we noted that the environment was not always visibly clean. Some people had bed rail covers on their beds, which were marked, and some were ripped. This remained at issue at this inspection. One person's bed had been stripped, and there was a ripped pillow in place, which staff had not disposed of.
● Although there were cleaning schedules in place, these had not been signed every day. A staff member said, "There is supposed to be 1 housekeeper on every day," but cleaning records did not show this was the case. There were gaps in records that showed bedrooms, toilets, dining room and corridors were not cleaned on a daily basis.
● It was unclear how cleaning was monitored in the service. A member of staff said, "There is no supervisor in post, but if I didn't do a good job, the team leader would tell me. I'm not sure if anyone looks at the completed cleaning forms though."
● We were informed that when no domestic staff were in the building, it would be the other staff's responsibility. A member of staff we spoke with confirmed this.

This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inspected but not rated

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection this key question was rated Inadequate. We have not changed the rating as we have not looked at all of the well-led key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served. We will assess the whole key question at the next comprehensive inspection of the service.

At the focused inspection in March 2023, we found the provider and registered manager had failed to operate effective governance systems. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A warning notice was issued in relation to Regulation 17.

At this inspection not enough improvements had been made, the provider was still in breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.

● At the focused inspection in March, we found there was not always effective or sufficient monitoring in place to ensure the quality of care provision. During this inspection, we identified continued issues with staff understanding risks to people and being clear about their roles.

●At the focused inspection in March, we identified accidents and incidents were not analysed effectively for patterns or trends and to ensure actions taken were effective. Potential safeguarding concerns were not always identified and escalated, as a result, further avoidable incidents occurred.

● During this inspection there continued to be concerns. For example, we found inconsistencies in incidents being reported in a timely manner, and information that was recorded on an incident form was not always escalated where there was a safeguarding concern. For example, an incident form reported an agency staff member had tried to give a person the wrong medication. There was no record of this concern being escalated to management. On another occasion, a person had been given someone else's transdermal patch, staff had not identified this or raised it as a concern at the time. Subsequently, the interim management team identified this once they came into post this was a month after it had happened.

● We found at the focused inspection in March staff were not always trained with the right skills to support people living at the home and clinical competencies were not being checked. During this inspection there was still concerns in this area. Despite staff being trained in areas such as diabetes and dysphagia, there were areas around documentation that showed training undertaken by staff and information shared was not consistently being implemented by staff. For example, food intake records for a person with SALT guidance in place showed the person had been eating food they had been assessed as not safe to eat, which indicated that staff were either unaware of the guidance or did not have a good understanding of what the

guidance meant.
● During the focused inspection in March communication between staff including senior staff was not always effective and put people at risk of harm. Some records were poorly maintained and organised including agency profiles, accident and incidents and staff handover records. This meant that there was inaccurate information held in the files and information pertinent for an audit trail was missing. Quality assurance processes had failed to identify these shortfalls in a timely manner.
● At this inspection we identified continued inconsistencies in handover information including important information about people that was not dated. This meant that it was difficult to audit this information because managers would not know what period it applied to. We also identified concerns with incorrect information about people's eating and drinking needs on menu's. This is important as people may be given a food that could put them at risk of harm. The interim manager addressed our concerns during the inspection and provided us with evidence of their plan to improve this going forward.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The interim manager was new in post at the time of inspection; they showed us a new system they would be implementing to analyse incidents and identify concerns in a timely manner.
● The interim management team told us that daily "huddles" had been put in place. They said, "We try to do regular training sessions as part of the daily huddle, particularly around choking etc." Staff told us they had been trained in how to support a person during a choking episode. Staff talked us through the steps they would take if this happened.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.
● Staff gave mixed feedback about any changes implemented since the focused last inspection in March 2023. Comments included, "I've not really been told about any of the changes. It may have been put in the communication book, but I've not time to read it" and, "They [interim management team] have made sure SALT plans and care plan updates took place. They made sure we knew how to access information, and they encouraged staff to ask."
● Morale amongst the staff team was mixed. One staff member said, "We are passionate about our residents, everything we do is for them. Now it's about making sure the residents are happy." and another said "On days when we have a lot of agency, then none, there aren't enough of us, but when we're all perm staff, there is more time."
● Incidents were reported. However, the interim management team had raised concerns around a general lack of accountability and a lack of escalation. One staff member said, "We have to provide the best care. There is no room for errors and mistakes."
● Since our last inspection, the provider had introduced an interim manager at the service. The interim manager had started to address some of the concerns identified previously. They were working to they were working hard to change the culture at the home and improve people's experiences, but this had not had enough time to take full effect. During the inspection the interim manager acted immediately on our concerns raised.