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St Michaels Lodge

Inspection report

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Tel: 01604250355

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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 the 21 August 2017 and was unannounced. St Michaels Lodge provides accommodation for up to 13 people living with mental health needs. At the time of our inspection there were 6 people living in the home.

There was a registered manager in post who was also the provider of the service. 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.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Although people's care and support files contained assessments of their capacity showing that they lacked capacity to make decisions in relation to their care there was no evidence that people had been involved in these capacity assessments. Best interest checklists had not been completed and there was no evidence to show that the provider had explored less restrictive options when developing people's plans of care.

The staffing levels within the home required strengthening. The availability of staff had impacted upon the improvements that the provider had implemented. People could not be assured that staff would consistently engage positively with them because they were focussed upon other tasks within the home.

Formal quality assurance systems required strengthening. The provider had not identified the shortfalls that we found in relation to how people's consent had been sought and their capacity to consent to their care assessed. The provider had not identified the shortfalls that we found in relation to the availability of staffing.

People's plans of care required strengthening to provide personalised guidance for staff in providing people's care in a person centred manner.

People could be assured that they would receive their prescribed medicines safely. Risks to people had been assessed and action taken to mitigate people's known risks. Staff were confident in the steps that they should take if they felt people were at risk of harm.

Staff had received the training, support and supervision that they needed from the provider to work effectively in their role. Staff felt well supported in their work. People could be assured that they would be

supported to access healthcare professionals.

The provider had taken steps to improve the culture within the home through introducing a programme of person centred care training and introducing a schedule of activities for people. We have made a recommendation in the main body of the report in relation the how the programme of activities and engagement for people could be strengthened.

The provider had a system in place to manage complaints.

At this inspection we found the service to be in breach of one regulation of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Staffing levels required improvement to ensure that there were always sufficient numbers of staff deployed within the home.

People could now be assured that they would receive their prescribed medicines safely.

Risks to people had been assessed and action taken to minimise the known risks to people.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the MCA had not been followed when developing people's plans of care.

People were support to have enough to eat and drink.

Staff received the training, supervision and support that they needed to work effectively in their role.

Is the service caring?

Requires Improvement

The service was not always caring.

Staffing levels impacted upon the quality of interaction and engagement between people and staff.

Feedback had been sought from people however, the systems used by the provider to gather feedback required strengthening.

People were treated respectfully by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's plans of care were focussed upon their areas of need and did not provide personalised guidance for staff to aid them

in providing person centred care.

The programme of activities within the home required further development and strengthening.

There was a system in place to manage complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Formal quality assurance systems required strengthening and embedding into practice.

The provider had taken steps to improve the quality of environment.

The provider had taken steps to address the task based culture that we had found in our previous inspection however, the availability of staffing impacted upon these improvements.

St Michaels Lodge

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21August 2017 and was unannounced. The inspection was completed by two inspectors.

Before the inspection we checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted and met the health and social care commissioners who monitor the care and support of people living in their own home.

During the inspection we spoke with four people living at St Michaels Lodge and two members of staff including one of the providers.

We reviewed the care records of four people who used the service. We also reviewed records relating to the management and quality assurance of the service.

Requires Improvement

Is the service safe?

Our findings

During our last inspection in April 2017 we found that the provider was in breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. That was because the provider had failed to ensure that safe systems of care in relation to the management of people's prescribed medicines were in place. We found examples of people failing to be provided with their prescribed medicines.

During this inspection we found that the provider had strengthened the systems that they used to monitor the administration of people's medicines. One person told us "The staff do the medication, I always get them the same time every day." The provider had introduced a system of audits to monitor the administration of people's medicines. These audits had been successful in improving the practice of staff administering medicines and no further errors had occurred since our last inspection. People could now be assured that they would receive their prescribed medicines safely.

People could not be assured that they would be supported by sufficient numbers of staff. The staffing levels within the service continued to require strengthening. During the day there was one member of staff working who was responsible for preparing people's main meals, observing people to maintain their safety as well as facilitating activities within the home. We observed that at times people were left for long periods of time without interaction and engagement with staff. Although people told us that there were sufficient numbers of staff working our observations were that at times people's experience of living in the home could be improved through increased staffing levels. Staffing levels had been reduced because a number of people who had lived at St Michaels Lodge no longer resided there. The provider told us that they monitored staffing levels and worked within the home during the week and that the staffing levels were sufficient to meet people's needs. The provider did not use a tool to determine the levels of staffing that were required in the home. If people had planned medical appointments the provider ensured that staff were available to support people to attend these appointments.

Risks to people had been assessed and plans of care had been implemented to provide guidance in reducing the assessed risks to people. One person told us "The staff keep people safe here." The staff we spoke to knew people well and were able to describe the action that they took to maintain people's safety.

People were supported by staff who were knowledgeable about potential risks and who knew how to protect people from harm. Staff had received training in safeguarding people and the staff we spoke to had a good knowledge of how to recognise the signs that someone may be at risk and the steps to take to escalate concerns to the registered manager or other outside agencies.

Safe recruitment processes were in place to protect people from the risks associated with the appointment of new staff. We saw that references had been obtained for staff prior to them working in the service as well as checks with the Disclosure Barring Service (DBS). The registered manager told us that she operated a thorough recruitment process and would only employ staff that she felt would be competent to work in the service.

Requires Improvement

Is the service effective?

Our findings

During our last inspection we found that the provider was in breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent. That was because restrictions were in place as part of people's plans of care however, the provider had not assessed people's capacity to consent to these restrictions.

During this inspection we found that formal assessments of people's capacity to consent to their care and support were recorded as having been completed however, people had not been involved in these assessments.

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.

The provider had not followed the principles of the MCA when developing people's plans of care. People had not been involved in the assessments of their capacity, the provider had not explored the least restrictive options when developing people's plans of care and there was no evidence that the provider had considered whether the strategies that they were using to support people in the home were in their best interest.

We observed people asking staff for cigarettes and being told that they had to wait because it was not yet the right time for these to be provided. A number of people living at St Michaels Lodge smoked cigarettes. Staff stored people's cigarettes securely, controlled people's access to cigarettes and ensured that people living in the home only smoked one cigarette per hour. Staff told us that they supported people to manage their cigarette consumption because without this support people would chain smoke and would not have sufficient funds to purchase cigarettes. There was no evidence that staff or the provider had explored other less restrictive ways to support people to manage their cigarette consumption or referred people to seek an Independent Mental Capacity Advocate to ensure that people's interests were appropriately represented when developing their plans of care.

The lack of adherence to the MCA code of conduct, including a failure to involve people in their assessments of capacity, lack of consideration for the least restrictive strategies to support people and lack of consideration of people's best interests constituted an on-going breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the registered manager had made appropriate DoLS applications to the local authority where people had been assessed as lacking

capacity to be able to consent to their care. However, we remained concerned that the principles of the MCA had been followed when the carrying out the initial capacity assessment in relation to these decisions.

Staff received the training, supervision and support that they needed to work effectively in their role. There was an on-going programme of training that was monitored closely by the provider to ensure that staff regularly updated their knowledge in key areas to enable them to continue to provide effective care and support to people in the home.

People received the support that they needed to eat and drink and were supported to maintain a balanced diet. One person told us "The meals are nice here. They all get made for us." There was a menu displayed within the communal dining room that had been designed by staff incorporating people's individual preferences. One member of staff told us "[Person] does not like sprouts so they will have different vegetables today."

People received the support they needed to access healthcare professionals. People had been supported to develop hospital passports to provide information for medical professionals about people's care needs and preferences in the event that they are admitted to hospital. The provider supported people to attend their planned medical appointments with their allocated GP's and psychiatrists.

Requires Improvement

Is the service caring?

Our findings

During our last inspection we rated this domain as inadequate and highlighted significant concerns in relation to the way home which people in the home were treated and valued. That was because people were not always treated with dignity and respect; we observed that staff did not always respond to people's requests for interaction and that people were expected to share toiletries.

During this inspection we found that people had been supported to purchase individual toiletries bags that they kept in their bedrooms and that everyone had access to their own toiletries. We observed that staff responded positively to people when they initiated conversation or sought engagement. One person told us "I think the staff are nice, they always are when I talk to them anyway." Another person told us "The best bit is how nice the staff are."

The provider had taken action to try and improve the culture within the service. Staff had received person centred care training to encourage them to reflect upon their practice and to ensure that they consistently provided care in line with people's individual preferences. However, the quality of engagement between staff and people remained inconsistent. The availability of staff meant that people were left on their own for prolonged periods of time. During the inspection we observed that people were left without any form of interaction with staff for up to one hour. People sought out interaction from inspectors during this inspection as a means of initiating conversation with another individual.

Some people had keys to their bedroom however, the provider had assessed that some people were unable to have a key to their room due to risks that this may pose. The provider told us that since our last inspection they had reiterated with people that they were free to enter their own room at any time.

The provider had introduced a comments box to encourage people to provide feedback about the care and support that they received; however no comments had yet been received. The provider had also sent out questionnaires to staff and people in April 2017 seeking feedback about the care and support provided at St Michaels Lodge however, no areas of development were identified as a result of these questionnaires.

People were supported by a stable staff team that knew people well. Staff were able to describe how they ensured that people's care was provided in line with their individual preferences. People's privacy was maintained in the home. We observed staff knocking on people's bedroom doors before entering and ensuring that people's personal confidential information was stored securely within the home.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection we found that the provider was in breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person Centred Care. This was because people were not supported to complete meaningful activities to aid their well-being. We also found that staff were not aware of people's plans of care and these plans required strengthening to guide staff in providing consistently personalised care and support. During this inspection we found that the provider was no longer in breach of this regulation however, the improvements that they had made required further strengthening.

During this inspection we found that an activities programme had been developed by the provider and resources had been purchased to enable staff to facilitate activities in the home. One person told us "The staff do activities now. I know that they do things like darts and board games here." The activities programme was newly developed and required further work to strengthen the scope of activities offered and to ensure that this programme was embedded into practice and focussed upon by staff.

The records of the activities that had been provided in the home showed that these were focussed upon 'in house' activities and that people were not supported to access activities or leisure opportunities outside of the home. Community based activities did not feature as part of the planned programme of activities. We recommend that the provider review their programme of activities to ensure that people are enabled to access the community and to take part in community based activities to further aid their sense of personal well-being.

Staffing levels also impacted upon the availability of meaningful activities within the home. People were unable to access the community without prior planning and engagement with the provider because the staffing levels were not sufficient to enable community based activities to take place on a regular basis.

People's plans of care continued to be task focussed and required further development to guide staff in providing consistently personalised care and support. People's plans of care had been reviewed since our last inspection however, continued to be focussed around people's areas of need and deficits. People's plans of care did not provide consistently personalised guidance for staff in meeting people's assessed needs in a person centred manner. For example, one person's mobility had recently deteriorated and had meant that they now required a ground floor bedroom. This person had been supported to move to a downstairs bedroom however, their plans of care did not provide guidance in supporting this person to manage their breathing and associated mobility needs.

The provider had a complaints policy in place however, had not received any formal complaints since our last inspection. We reviewed the records maintained relating to complaints and saw that no formal complaints about the home had been received. The provider had recently introduced a comments box to enable people to provide feedback anonymously should they wish to. However, this system of gathering feedback was newly introduced and the provider had not yet received any comments from people.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection we found that the provider was in breach of Regulation 17 (1) (a) (e) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. That was because the provider had failed to provide appropriate systems or processes to assess, monitor and act upon feedback from people to improve the quality and safety of service.

During this inspection we found that the provider was no longer in breach of this regulation. The provider had taken steps to improve the quality of care that people received however, the formal systems for quality assurance continued to require strengthening.

The provider had taken steps to improve the environment. The home had been decorated throughout and broken items of furniture and old flooring had been replaced. The garden had also been turfed and rubbish had been removed to create a more pleasant outside space for people to use. The provider told us that they planned to develop these improvements further by replacing the kitchen and flooring in the communal lounge to improve people's living environment and was in the process of receiving quotes for these additional works.

The provider regularly worked in the service providing people's day to day care and monitored the quality of care and support that people received through their daily observations. The provider had introduced a formal system of audits that had been effective at addressing the shortfalls that we identified during our previous inspection in relation to medicines and people could now be confident that they would receive their prescribed medicines safely.

However, formal quality assurance systems and oversight of people's care and support continued to require strengthening. The provider had not identified that the principles of the MCA had not been implemented appropriately within the home. The provider had also not taken steps to review the ways in which they gathered and acted upon feedback from people since they had introduced a comments box which had not yet been successful in encouraging people to provide feedback. However, questionnaires had been sent to people living in the home in April 2017 and an analysis of the responses that were received had not highlighted the need for any specific action to be taken by the provider.

The provider had not taken steps to review the staffing levels within the home to ensure that sufficient numbers of staff were consistently deployed to enable people to partake in meaningful activities. Although the provider had taken steps to address the task based culture that we found during our last inspection through the introduction of person centred training for care staff and a focus upon developing a programme of activities; the availability of staffing had impacted on this shift in culture.

The provider was visible throughout the home and knew people well. We observed the provider initiating conversation with people and people appeared relaxed in their presence. Following our last inspection the provider submitted an action plan to CQC to detail the improvements that they intended to make to address the shortfalls that we had identified. The provider told us that they were committed to improving the care

and support provided to the people living at St Michaels Lodge. During this inspection we found that the provider had been following their action plan however, some areas of the care and support that people received continued to require improvement.

The service was being managed by a registered manager who was aware of their legal responsibilities to notify CQC about certain important events that occurred at the service. The registered manager had submitted the appropriate statutory notifications to CQC such as DoLS authorisations, accidents and incidents and other events that affected the running of the service. When we inspected the service the rating from our previous inspection was not displayed however, the provider took action to ensure that the rating was displayed.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The lack of adherence to the MCA code of conduct, including a failure to involve people in their assessments of capacity, lack of consideration for the least restrictive strategies to support people and lack of consideration of people's best interests constituted an on-going breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

The enforcement action we took:

We issued a warning notice to the provider.