Runwood Homes Limited

St Michaels Court

Inspection report

St Michaels Avenue
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: St Michaels Court is a care home with nursing for up to 86 people, some of whom may be living with dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

People's experience of using this service:
Although there had been some made, further improvements were still needed to ensure people received good quality, safe care at all times.

There had been a high turnover of management staff since our last inspection resulting in a lack of consistent leadership and support for staff.

Improved quality checks had been implemented, but not yet embedded and sustained.

The service was not always safe. Improvements had been made in risk assessments, for example around pressure care, however some risks were still not mitigated fully. Further improvements were required around some areas of medicines records.

There had been some improvements in the availability of staff, but overall there remained a lack of enough staff available to support people.

People had improved access to healthcare professionals, however, recommendations were not always followed and care plans not always updated.

People continued to receive care that was not always individualised and met their preferences. However, there were some improvements in the provision of activities for people to engage in.

Medicines were not always being managed safely at the home.

Staff supported people to maintain their privacy, however at times people felt upset because they had not received support to use the toilet in a timely way.

Improvements had been made in safeguarding people, and management staff were aware of their responsibilities to investigate and report concerns.

There had been improvements in the provision of enough food and drink for people, and this was well-recorded by staff.

People were more involved in their care, as well as families, where appropriate.

Improved recording around people's mental capacity meant it was clear what decisions had been made in people's best interests.

Staff worked well as a team and felt more supported by the management team.

This service is rated Inadequate overall, and therefore remains in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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.

Rating at last inspection: The previous inspection took place on 12 December 2018, rated as Inadequate overall, and in all key questions. The report was published 29 January 2019. The service was in breach of Regulations 9, 10, 12, 13, 14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Registration Regulations 2009. We met with the provider following this inspection and requested an improvement plan. They kept us updated regularly of their progress on this plan. Improvement plans were reviewed as part of this inspection.

Why we inspected: Services placed in special measures are inspected within six months of the publication date of the report to determine if sufficient levels of improvement have been made. However, we received further complaints and concerns about the service and carried out an urgent inspection.

Follow up: We will continue to monitor the service according to our schedule for returning to locations rated Inadequate.

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

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 always safe.

Details are in our Safe findings below.

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our Responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our Well-led findings below.

Inadequate

St Michaels Court

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by three inspectors and a member of the medicines team.

Service and service type:
St Michaels Court is a care home with nursing for up to 86 people. The service supports some people living with dementia. The accommodation comprised a purpose-built property over two floors. When we inspected, there were 42 people living in the home.

There was not a registered manager in post at the time of this inspection. A 'registered' manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced.

What we did:
Before inspection: We reviewed information we had received about the service since the last inspection. This included concerns and complaints we received, as well as details about incidents the provider must notify us about. We liaised with third party stakeholders.

During the inspection we spoke with 14 people and three relatives. We spoke with 10 staff including a cook, an activities coordinator, an administrator, an agency nurse, an agency carer, four daytime carers and a night carer, as well as a visiting healthcare professional. In addition, we discussed the home with the management team which consisted of two deputy managers, a regional manager and a peripatetic

manager.

We reviewed six care plans, plus samples of further care plans and daily records, and medicine administration records for 15 people. We observed medicine administration and spoke with four members of staff specifically about medicines.

Requires Improvement

Is the service safe?

Our findings

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

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management

• We found at the last inspection in December 2018 risks to people were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received a number of concerns prior to this inspection about the management of people's safety.

● We found that some risks were not fully mitigated. For example, we saw that one person was sitting in their chair with a sensor mat in front of them, and their walking frame out of reach. The person's care plan stated they should have their frame 'with them'. This person had fallen twice in the previous six weeks.

● Where people were at very high risk of falls, care plans did not have specific guidance about how often staff should supervise or check on people. On one occasion during our inspection visit, an inspector intervened due to a concern around one person getting up from the chair and being at risk of falling.

● Staff gave us inconsistent information about risks to people, including their health conditions and risk of falls, and whether one person had a sensor mat in place. Risks to people documented in their care plans were not always consistent with what a healthcare professional told us.

● There were not always full risk assessments and care plan guidance regarding people's health conditions. For example, where people had diabetes there was not always guidance on what their expected or usual blood sugar ranges were, and when to consult other healthcare professionals such as the diabetic nurse.

● There was no risk assessment for one person who was administering their own inhaler, or for their associated health condition. The risk assessment for the inhaler was completed the following day after our inspection visit.

● There was insufficient written guidance to help staff give people their medicines prescribed on a when required basis appropriately and consistently. Some guidance was not available for medicines prescribed in this way and some lacked detail about the appropriate circumstances for their use.

● When people had known allergies and sensitivities to medicines, records were sometimes inconsistent which could have led to errors and medicines being administered inappropriately.

● These concerns constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were improvements in the management of pressure ulcer risks. Staff had good knowledge of any pressure relieving equipment people had, and we saw this was used and checked properly.

Staffing and recruitment

● We found at the last inspection in December 2018 that there were not sufficient numbers of staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We received information of concern prior to the inspection around staff conduct and staffing levels. We found staff were not always available to support people when needed.
● One person explained, "If they're busy, it could take a half an hour, but I don't worry, I'm not impatient." Another person said, "[Staff] do keep you waiting sometimes, up to half an hour, when you need the toilet it's not funny." A third person added, "Staff don't come very often, that's the trouble, if I want to go to the toilet, it's too late, I hate it. I understand their problems, they've got other people to see to. It doesn't happen every day but sometimes it's horrible."
● We received mixed feedback from staff about staffing levels. Comments included, "Quite often I find that there isn't enough time to get everyone properly washed and dressed."
● The rota covering the previous six weeks demonstrated that staffing levels at night were not always consistent and ran between two and four care workers alongside a team leader and a nurse.
● The majority of people living on the ground floor required two staff for any care interventions or manual handling.
● These concerns constituted a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There continued to be recruitment checks in place to help ensure that suitable staff were employed which included references and criminal record checks.

Systems and processes to safeguard people from the risk of abuse
● There were improvements in the systems which protected people from the risk of avoidable harm and abuse.
● Staff were aware of safeguarding processes including reporting, and the provider had reported any concerns appropriately, and taken action where concerns were raised.

Using medicines safely
● For one person, their care plan stated that they did not have creams prescribed. However, their daily notes stated, 'cream applied as prescribed,' regularly.
● There was a system in place for ordering and giving people their medicines as prescribed.
● Medicines were stored securely.
● Medicines were given by staff and recorded on Medicine Administration Records (MAR charts).
● Staff had received training and all except one had recently been assessed for their competency to handle and give people their medicines safely.
● Observations of staff showed that they followed safe procedures and took time with people when giving them their medicines, however, we noted the morning medicine round was lengthy and some people received their medicines later than scheduled and intended by prescribers.

Preventing and controlling infection
● Infection control practices were improved. The home appeared clean throughout. Communal areas and people's rooms were visibly clean and tidy.
● We saw that staff had personal protective equipment (PPE) such as gloves and aprons available for when they were supporting people with personal care.

Learning lessons when things go wrong
● Accidents and incidents were recorded. However, due to inconsistent management they had not always been consistently and effectively reviewed.
● Concerns raised by healthcare professionals were not always recorded and resolved appropriately.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- The healthcare professional we spoke with told us that relationships between staff and healthcare professionals had improved, with better communication. However, staff did not always update care plans with recommendations and therefore we were not assured these were always followed.
- We saw evidence of healthcare professionals being involved with people's care when needed, for example, physiotherapists, speech and language therapists and chiropodists.

Staff support: induction, training, skills and experience

- Staff reported that they had not received regular supervision meetings.
- We received mixed feedback about whether new and agency staff were supported enough.
- Two staff we spoke with did not know about people's healthcare and dietary requirements.
- One agency staff member said, "I'm not quite sure how to look at care plans (on electronic system)." One staff member said, "The care [people] receive depends on the staff on duty. Today we have good carers, but a weaker carer impacts on people."
- Staff received training relevant to their role, for example in areas such as safeguarding, fire and manual handling. Further training in health conditions such as diabetes would be beneficial in meeting the specific needs of some people, and not all staff had received this.

Supporting people to eat and drink enough to maintain a balanced diet

- We found at the last inspection in December 2018 that people were not adequately supported with their nutritional and hydration needs. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was no longer in breach of this Regulation.
- There were improvements in the provision of support for people to eat and drink enough.
- Staff recorded food and drink for people and we saw that people were receiving enough to drink.
- People gave positive feedback about the food overall, including the choice available to them. A staff member told us, "The staff eat with them [people] to encourage them to eat, so I think it's very good."
- We saw that staff supported people to eat according to their care plans. The cook was knowledgeable about people's needs in the home and had access to up to date information about people's dietary requirements.
- Two members of staff said that there was not always good organisation of ordering food and ingredients, which meant that some things were not always available. One staff member told us they would go to the local shop to pick this up if needed, but this was not in line with the budgeting.

● A 'fluid lead' explained to us that part of their role included encouraging fluids and checking people had enough to drink.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed in terms of what care they required and what their dependency levels were. This information was used to inform a care plan, however some further information was required in these plans.

Adapting service, design, decoration to meet people's needs
● A relative said, "It's purpose built which makes it much easier to get around." People had spacious rooms with ample light, and there was a pleasant outdoor seating area and garden which people were using during the day.
● The environment had been well adapted to people's needs. On the floor where people were living with dementia, there were sensory items available for people, and posters on their doors with some information about them.

Ensuring consent to care and treatment in line with law and guidance
● The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
● People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
● We saw that there were decision-specific assessments in place for people who lacked capacity, for example for medicines administration and staying in the home. We saw records of how best interests' decisions had been arrived at, and who was involved, for most aspects of people's care such as medicines administration and personal hygiene.
● We saw that least restrictive options were used when people were deprived of their liberty for their safety. No DoLS applications had been approved since our last inspection.
● Staff had a good understanding of consent and we saw they put this into practice.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI: People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence
● We found at the last inspection in December 2018 the key question for caring was rated inadequate. Staff did not uphold people's dignity. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was no longer in breach of this Regulation.
● We received concerns around people's dignity prior to the inspection, however we found some improvements had been made. People told us this was more often at night. Whilst one staff member also reflected this, another said this had improved.
● Some people's dignity was affected due to at times not receiving support to go the toilet when they needed to.
● Some language staff used in the records did not promote people's dignity, such as reporting one person's behaviour as, 'out to cause trouble'.
● During our inspection visit, people appeared clean, well dressed and dignified.
● Staff respected people's privacy and approached them discreetly when needed, if they required personal care.

Ensuring people are well treated and supported; respecting equality and diversity
● People we spoke with told us staff were polite and respectful towards them. One person said, "[Staff] really care." A relative said, "Staff are lovely."
● We saw positive, friendly and humorous interactions between staff and people.

Supporting people to express their views and be involved in making decisions about their care
● There were improvements in involving people and their relatives in their care. We saw that the provider had engaged some people in attending care plan reviews, and a relative confirmed they had attended this.
● Relatives told us, and staff confirmed that if anyone had a change in their health or an incident, staff informed family. One relative said, "[Staff] tell us what they are doing."
● Staff told us how they supported people to make choices where they had variable capacity due to living with dementia, for example about what to wear.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Inadequate: Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; End of life care and support

- We found at the last inspection in December 2018 that care was not person-centred. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- We received information prior to the inspection that the service was not meeting people's needs. We found people did not always receive person centred care according to their individual needs and preferences.
- One person said that the responsiveness overall had improved since they moved bedrooms. They said, "It's better than when I was upstairs, [staff] seemed to ignore me, if I rang the bell they might answer it but they didn't do anything. Now they might take a while to answer, but they're usually quite good when they come." They added, "I don't have a wash until 12:15pm or so because that's when the staff get around to me. If I would choose I prefer the middle of the morning, they usually say they've got other people to help."
- A staff member told us people did not always go to bed when they wanted to, as there was an expectation for day staff to support people to get ready for bed by 7pm. They added that they supported some people to shower in the afternoon, due to not having time to do this morning or evening.
- A staff member said, "I love chatting to the residents, but don't always have time." This was closely reflected by a further two staff.
- There were not always planned one to one activities available for people who preferred to stay in their rooms or were cared for in bed.
- Care plans were not always person-centred with details of people's preferences. There were some details, such as what time people preferred to get up in the morning, but limited guidance in other areas.
- Care plans were not always accurately reviewed and updated. We saw for one person, staff had recorded two behavioural incidents prior to the monthly review, but the review on 29 April 2019 said, '[Person] has not shown any signs of challenging behaviour.'
- Where healthcare professionals updated staff around people's needs, this was not always added to the care plan and communicated to staff.
- Care plans did not contain person-centred guidance on how to manage people's conditions. The provider put some further plans in place following our inspection, however these were generic rather than person-centred, and contained inaccurate information.
- Staff did not always accurately record interventions in people's daily notes. We saw that one person was distressed in the morning and complaining of pain. A staff member spoke with them, however they recorded that the person was asleep.
- When healthcare professionals carried out interventions, raised concerns or made recommendations, this was not always recorded and updated in the contemporaneous records.

● End of life care plans were either brief or absent. There were not always records of conversations with people and families around their end of life wishes.
● These concerns constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was an improvement in the provision of group activities for people, and the management team explained how they were planning on further improving this across the organisation.
● We received mixed feedback from staff about whether activities met people's needs. Activities included exercises, games, quizzes and occasional outings. There was visiting entertainment on occasion, such as singers. The activities coordinator was planning a fashion show in the home in a couple of weeks' time.
● Staff told us they communicated well between shifts in handover and stayed up to date with people's changing needs.
● Everyone we saw had access to a call bell, and if they were not able to use it this was documented in their care plans.

Improving care quality in response to complaints or concerns
● There had been one complaint since our last inspection which had been resolved appropriately.
● People and relatives felt comfortable to raise any concerns with staff.

Inadequate

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- We found at the last inspection in December 2018 that governance systems were not effective in monitoring and improving the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- There was a lack of consistent management for the home. There was no registered manager in place and there had been a high turnover of management staff since our last inspection. A staff member said, "We've had a lot of change. We need to get a management team that wants to stay."
- The management team consisted of two deputies, a regional manager and a peripatetic manager. The regional and peripatetic manager had been involved with the home for only a few weeks and they did not know people's needs well.
- There had been several management staff employed in the home since our last inspection, who have not remained in post. At this time, we are not confident in the provider to make and sustain the improvements required.
- There were not always accurate, contemporaneous records around people's care needs. Reviews were not always meaningful and accurate.
- The provider had put in place further checks, including regular night spot checks. This had led to some improvements; however, they had not been continued for long enough to assure us of the sustainability of improvements. Furthermore, not all issues we identified had been found by the provider.
- Regular checks were in place to check the accuracy of medicines administration records (MAR), and there were checks for some medicines each time they were given to people. However, these were not always effective because we noted gaps in these records.
- Other further checks include auditing and monitoring of the service, for example in infection control, however this needed to become fully embedded into practice to sustain improvements.
- These concerns constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were aware of their roles to provide safe care for people, and were motivated to provide this. Further support was needed to ensure good practice and culture was embedded.
- Some staff had roles leading in particular areas, for example, 'dignity champions' and, 'fluid leads'. This may have contributed to improvements seen in these areas since the last inspection.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

● A staff member told us, "It's better than it was. It's more organised." Other staff reflected that the lack of manager had been destabilising for the team. Further sustainable improvements in care provision were still required to bring the home's rating up.
● The management team were open, transparent and visible to people and families. They were aware of their duty of candour responsibilities and communicated effectively with them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● All the relatives we spoke with were happy with their family member's care.
● We saw that the provider had made efforts to engage families in the running of the service, by meeting with them and communicating with them.
● The provider had implemented regular staff meetings to keep them informed and involved them more actively in the running of the home, as well as undergoing the improvements needed.

Continuous learning and improving care
● The service had followed their improvement plan and taken sufficient actions to ensure people living in the home were safe and improvements had been made to people's care. A staff member told us, "There is better communication, and everyone wants to make improvements."
● They had also worked closely with other homes within the provider's group to make some improvements since the last inspection.

Working in partnership with others
● The service had worked with the local authority and CQC to make some improvements. However, there had not been a manager in post for a sufficient time to get to know people and staff. This meant that liaising where needed, for example with the CCG (Clinical Commissioning Group), or Continuing Care about people's needs, was not consistent.