Leonard Cheshire Disability

St Michael's - Care Home with Nursing Physical Disabilities

Inspection report

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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 to up to 36 people. The service provides support to people with physical disabilities, nursing needs and people with a learning disability and autistic people. The building is a large period building with a communal dining area. There is a physiotherapy room on site. At the time of our inspection, there were 20 people using the service.

People's experience of using this service and what we found
This was a targeted inspection considering the assessment, monitoring and management of choking risks to people with eating and drinking needs.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support, Right Care and Right Culture
The provider did not always have oversight of the quality of care and safety around the risks of people choking. The provider and registered manager had not always ensured people received safe or good quality care. This put some people's safety at risk and meant people did not always receive a safe service. Not everyone had up to date information in their care plans about their eating and drinking needs. Not all risks were being identified, and where they were, this was not always updated in care plans and risk assessments for staff to read. Handover information shared between staff did not accurately reflect changes to people's needs. No one else had come to harm because of this. We observed positive interactions at mealtimes with 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 6 June 2023). At the time of this Inspection, the provider had not produced an action plan to show what they would do and by when, to improve the service. The service remains inadequate and is in special measures.

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the assessing,

monitoring and management of risk of choking for other people living at the service. This inspection examined those risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) at this inspection.
Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan specifically around risk of choking to people with identified eating and drinking needs from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor the information we receive about the service, which will help inform us when we next inspect.

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	**Inspected but not rated**
Is the service well-led? The service was not always 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.

This was a targeted inspection to check on a specific concern we had about assessing, safety monitoring and management of choking risks to people who had identified eating and drinking needs. We did not provide a rating for this inspection.

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/or 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 must 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. The registered manager was not available during the inspection however a care manager was present.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed 9 care plans, including risk assessments, daily records of what people ate and drank and handover information between staff. We also reviewed records relating to the management of the service, including accident and incident records and audits.

Following the inspection
We met with the provider to discuss our feedback from the inspection. The provider took action to remedy the concerns we raised.

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 we rated this key question Inadequate. We have not changed the rating as we did not look at all of the Safe key question at this inspection.

Assessing risk, safety monitoring and management

● Prior to the inspection, we received information from the provider that there had been an unexpected death at the service. The unexpected death at the service raised concerns that people using the service may be at risk of choking. Therefore, we decided to review people's care and support plans who had eating and drinking needs. We found inconsistent information about people's needs in 5 care plans care plans we reviewed.

● Some people were at risk of choking because people's care plans and risk assessments had not been regularly reviewed and updated.

● Staff did not always follow people's professional assessments and guidance regarding foods they could eat safely. We found examples in 1 record of staff recording that people had eaten food not in line with their SALT (Speech and Language Therapy) guidance.

● One person's SALT guidance had not been reviewed since 2018. Their risk assessment for eating and drinking had not been updated since 2021, and it was not clear when the support plan was last reviewed and updated.

● Handover information that was shared with all staff, including agency staff, at the start of each shift had not always been accurately updated to reflect changes to people's eating and drinking needs, potentially putting people at risk of having the wrong food and drink.

● We saw evidence that not all agency staff had the relevant skills and training to support the people living at the service. We were not assured that all staff had the relevant skills and training to support people safely.

● We saw evidence that the service had recently requested a review of some people's SALT guidance. A referral to the GP for a review of people's SALT guidance had been made for people on 16 June.

Learning lessons when things go wrong

● Action had been taken to support the service since the unexpected death; an operations manager had been based at the service full time, and care plans were being reviewed and updated. However, there was still some outstanding information that had not been reviewed in a timely manner, potentially putting other people at risk.

This was an a additional breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks to people who were at risk of choking were not always assessed, monitored and managed to keep people safe.

● We raised our findings with the provider following our inspection, they started to take action to address our concerns.

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.

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

- We identified shortfalls in care planning and staff practice at St Michael's - Care Home with Nursing Physical Disabilities, which put people at risk of choking incidents.
- There were systems in place to monitor the quality and safety of the service. However, we found these systems and processes were not always effective at identifying and addressing the issues we found during the inspection.
- There was a lack of oversight. Care plans which included peoples' eating and drinking risks, had not been audited or reviewed on a regular basis.

Continuous learning and improving care

- At the time of the inspection, the service did not have an up to date service improvement plan in place.
- There had been a choking incident with 1 person in the last few months; at the time new SALT, guidance for the person had been provided by the Speech and Language therapist. Although this guidance had been added to the person's care plan, food that had been identified as putting the person at risk of choking was still being recorded on the daily food intake sheets for the person. The registered manager and provider failed to ensure that the systems in place to mitigate the risk of choking were being communicated and practised by all staff. We saw no evidence that the person had come to harm as a result of this.
- Some agency staff profiles showed they did not have the necessary skills and training to support the people living at the service.
- The provider had not identified any learning following the incident and the person's death. No action had been taken in the form of staff supervision or team meetings. Staff told us they had not been made aware of any changes or that they should do anything differently in caring for people since the death of the service user.

This was an a additional breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always operate effective systems and processes to assess and monitor the safety of people who were at risk of choking because of an identified eating and drinking need.

- We raised our findings with the provider following our inspection, they started to take action to address our concerns

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1),(2)(a)(b)(c) HSCA RA Regulations 2014 Safe care and treatment Risks to people who were at risk of choking were not always assessed, monitored and managed to keep people safe

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1),(2)(a)(b)(c)(e)(f) HSCA RA Regulations 2014 Good governance The provider did not always operate effective systems and processes to assess and monitor the safety of people who were at risk of choking.