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St Michaels House

Inspection report

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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?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection took place on 22 and 29 August 2017. St Michaels House provides accommodation for up to 13 people living with mental health needs. At the time of our inspection there were 11 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.

Following the last inspection of St Michaels House in April 2017 the provider was rated as inadequate and placed into special measures. During this inspection we found that the provider had implemented improvements in a number of areas however, these improvements required further development to ensure that they were sufficiently embedded into practice. There was a lack of oversight of people's care and support from the provider and an appropriate system to monitor and improve the quality and suitability of care and support that people received had not been implemented. This had resulted in ongoing breaches of regulation and a risk of harm posed to people due to the lack of cleanliness of the home. This inspection found that there was not enough improvement to take the provider out of special measures and that the well-led domain remained inadequate.

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.

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 home was dirty and a number of areas on the ground floor including the laundry room were mouldy and posed a risk of harm to people. Throughout the home and in people's bedrooms we found broken items of furniture that were in use, dirty carpets and the home was in need of redecoration and updating. The provider had submitted an action plan to CQC in August 2017 detailing the improvements that they

intended to make to the environment however, appropriate and timely action had not been taken since our last inspection.

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.

A system of quality assurance to monitor the environment and key aspects of people's care and support had not been implemented. This had resulted in the shortfalls that we identified during this inspection failing to be identified or addressed by the provider.

A programme of activities had been introduced to increase people's sense of well-being. We have made a recommendation within the main body of the report in relation to how this programme of activities can be further developed.

People could now be assured that they would receive their prescribed medicines safely. Staff had been recruited safely and received the training, support and supervision that they required to provide people's care and support.

People were supported to have enough to eat and drink and to access healthcare professionals when they needed to.

Staff knew people well and the engagement between staff and people had improved since our last inspection. However, the availability of staffing sometimes impacted detrimentally the engagement between staff and people living in the home.

People had plans of care in place describing their care needs however, these required strengthening to provide person centred guidance to staff on how to meet people's care and support needs consistently.

At this inspection we found the service to be in breach of four regulations 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.

Improvements were required to the cleanliness of the home. The home was dirty and areas of the home were covered in mould posing a risk of harm to people.

Staffing levels required improvement to ensure that sufficient numbers of staff were consistently deployed.

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

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the MCA had not been applied appropriately.

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

People were supported to have enough to eat and drink and to access healthcare services when they needed to.

Is the service caring?

Requires Improvement

The service was not always caring.

The interaction between staff and people had improved since our last inspection.

The views and feedback from people using the service had been sought and acted upon by the provider although these systems required strengthening further and embedding into practice.

The availability of staff impacted upon the ability of care staff to engage positively with people living in the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's plans of care required further development to ensure that staff were provided with the guidance they needed to provide consistent person centred care.

People were supported to maintain relationships that were important to them.

There were sufficient systems in place to manage complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Appropriate systems to monitor the quality of care that people received had not been implemented.

Shortfalls that we found in relation to the cleanliness and suitability of the environment had not been identified or acted upon by the provider.

Appropriate strategies to address previous breaches of regulation had not been deployed by the provider.

St Michaels House

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 22 and 29 August 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 the home.

During the inspection we spoke with four people living at St Michaels House and three members of staff including one of the providers, the cleaner and one member of care staff.

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(1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. That was because people could not be assured that they would receive their prescribed medicines safely.

During this inspection we found that the provider had taken action which meant that people could now be assured that they would receive their prescribed medicines safely. One person told us "The staff look after all of my tablets and give them to me when I need them." The provider had introduced a system of audits to monitor the administration of people's medicines which had been successful in reducing the number of medicines errors. Since our last inspection the provider told us that they had not found any discrepancies in the numbers of tablets held in stock which meant that people had received their medicines as prescribed. The staff administering people's medicines had received the training that they needed to do this safely and competently.

People could not be assured that they would be supported to live in a safe and homely environment. The home was dirty, poorly maintained and we identified that some areas of the home posed a potential risk of harm to the people living in the service.

The ground floor of the home which consisted of a communal television room and staircase to people's bedrooms smelt strongly of damp. The corridor and stairs leading to people's bedrooms had mould on the window ledge, walls and doors. This mould presented a potential risk of harm to people who accessed these areas.

The laundry room was dirty, smelt of damp and had mould on the walls and work surfaces. The walls, cleaning equipment and work surfaces were also dirty and had ingrained dust and debris on them. People's clean laundry was stored in this room and this presented a risk of harm to people living in the home through the allergens present in the mould and dirt. The service was currently providing care to one person who was receiving medical treatment that impacted upon their immune system and resistance to infection. The service was also supporting another person chronic obstructive pulmonary disease (COPD), the mould and ingrained dirty posed a risk that this person's breathing difficulties associated with their diagnosis of COPD may become worse.

One person's mask for their nebulizer which they used to inhale a prescribed medicine was stored on their bedroom floor and was excessively dirty. This posed a risk of harm to this person due to the risk of infection from the ingrained dirt in the face mask and tubing used to administer their medicines.

We bought our concerns in relation to the cleanliness and safety of the environment to the attention of the provider on the first day of the inspection. The provider told us that they did not usually access this area of the home and was not aware of the level of dirt and mould that was present. When we returned to the service on the second day of inspection the provider told us that they had not taken any action to clean these areas of the home.

The failure to ensure that the home was kept sufficiently clean and that action was taken to protect people from the risk of harm through the spread of infection was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a need for the provider to review the staffing levels within the home. The numbers of staff deployed within the home were not sufficient to consistently facilitate meaningful engagement for people. People told us that they felt there were enough staff working within the home. However, during the inspection we observed that for the majority of the time there was only one member of care staff on duty to prepare the main meal, provide oversight of people's care needs and to facilitate activities for people living in the home. The staffing levels in the service impacted upon people's choice of activity. People were unable to access the community without prior planning and consultation with staff and the provider to ensure that additional staff were supplied to facilitate this. The rotas showing the numbers of staff working were nor clear and did not accurately reflect the number of staff on duty.

Staff were aware of how to report safeguarding concerns if they identified that an individual may be at risk. One member of staff told us "If I ever had any concerns I would report them straight to [Provider]." Staff had received training on how to protect people from harm. Staff were aware of the assessed risk to people and followed people's plans of care in order to mitigate people's known risks. For example; people cared for in bed had their pressure relieving mattress set at the correct setting and staff monitored their skin integrity closely.

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 they operated a thorough recruitment process and would only employ staff that they 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. This was because people's ability to consent to their care and support had not consistently been considered by the provider when developing people's plans of care.

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.

One person told us "The thing that I'm unhappy about is that I'm not allowed my own cigarettes, they give me one every hour. They say it's to help me cut down but it just gets me more angry." A number of people living at St Michaels House 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 were supported to access on-going training and development that was relevant to their role. One member of staff told us "We had Person Centred Care training which was interesting. We learnt to try and encourage people in different ways. Don't just take no for an answer when asking about activities try asking in a different way." There was an on-going programme of training to ensure that care staff regularly refreshed their knowledge in key areas such as safeguarding.

Staff also had access to regular supervision and support from the registered manager to enable them to reflect upon their practice and identify areas of development. The provider had recently introduced a system of observational supervision which was completed by senior care staff to provide coaching and mentoring to care staff. This system of supervision was newly introduced, had not yet been provided for all staff and was not therefore embedded in practice.

People were supported to have enough to eat and drink and were supported to maintain a balanced diet. One person told us "The food is nice. There is always plenty of it and we of get a choice." People who required support to eat and drink received the support that they needed. There was a menu displayed in the main dining room which had been adapted in line with people's preferences. For example; one person requested roast gammon and this meal was provided as part of the menu.

People were supported to access health services when they needed to and referrals were made to people's allocated health professionals in a timely manner. Staff were vigilant to any changes in people's health and took action to enable people to access relevant healthcare professionals. Where health professionals had implemented plans of care these were followed by staff in the home.

Requires Improvement

Is the service caring?

Our findings

During our last inspection in April 2016 we found that the provider was in breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and Respect. That was because the quality of interaction and the relationships between staff and people living in the home was inconsistent. People's feedback about their care and support had also not been sought or acted upon.

During this inspection we found that 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.

We observed examples of positive interaction between people and staff with staff encouraging people to complete activities and tasks within the home to aid their sense of well-being. However, this interaction remained inconsistent and was impacted by the availability of staffing. Whilst two members of staff were on duty there were sufficient numbers of staff to provide social stimulation and activity for people. However, at times only one member of staff was available and during these periods staff remained focussed upon the tasks that they needed to complete within the home rather than upon providing consistently positive engagement for people.

The provider had introduced a comments box that was placed within the communal dining area to gather feedback from people living at the service. We found that this system of feedback had been initially successful with people providing feedback about the meals and activities within the service. For example one person requested that they would like to have a bus pass and we saw that staff had supported this person to obtain a bus pass that they were able to use on public transport. Another person requested a different cereal to the one that was available to people and the provider ensured that the cereal requested was purchased and made available. However, this system of gathering and acting upon feedback still required further development to ensure that it was embedded in practice. No comments had been received from people since June 2017. 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 House 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. For example; staff described how they had adapted the way in which they supported one person with moving and handling in response to them showing signs of discomfort.

Staff ensured that people's privacy was maintained when they were supporting people with their personal care. For example, we observed staff closing people's bedroom doors when supporting them with personal care. We also found that staff ensured that people's personal records such as care plans were stored securely and were not accessible. However, we identified that two bathrooms did not have a lock on which posed a risk that people's privacy may be compromised.

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 people's plans of care required strengthening to guide staff in providing consistently personalised care and support. During this inspection we found that the provider had taken action and was no longer in breach of this regulation however, the improvements that they had implemented required further development.

During this inspection we found that the provider had introduced a programme of planned activities. One person told us "I don't really join in the activities but the others seem to enjoy them." We observed that staff encouraged people to take part in the planned activities within the home. For example; we observed three people actively engaged in a game of magnetic darts with staff and it was evident that they enjoyed this game and it contributed to a more social atmosphere within the home. The provider had also introduced a system of recording what activities people had taken part in July 2017. We observed that the programme of activities had initially been successful when first introduced, with records showing that people often chose to partake in the planned activities. However, records showed that towards the end of July and August 2017 people were increasingly refusing to take part in the planned activities. The provider needs to ensure that they continually review the strategies that they deploy to encourage people to take part in meaningful activities to aid their sense of well-being.

The activity programme consisted of a range of activities such a darts, karaoke and board games that were completed within 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.

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. They did not provide staff with sufficient guidance regarding how to support people to build on their strengths or improve and maintain their skills and independence. 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 health had recently deteriorated significantly. Their care and support needs had increased as a result of this and they now required support to eat their meals and increased support with personal care. The detail within this person's plan of care did not reflect the enhanced level of support that staff needed to provide on a day to day basis and as a result of this there was a risk of this person receiving inconsistent care and support.

People knew how to make a complaint and to provide feedback about the support they received. One person told us "If I needed to make a complaint I would go to speak to them in the office." 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.

Inadequate

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.
This was because the provider had not deployed appropriate systems or processes to assess, monitor and improve the quality and safety of the care that people received.

During this inspection we found that the provider had continued to fail to deploy a system of audits to sufficiently assess the cleanliness and suitability of the environment. We identified that a number of areas of the home were dirty and covered in mould and that this posed a risk of harm to the people living in the home. We raised this concern with the provider who was available during the inspection who told us that they had "Never been in the laundry room before and we don't complete any sort of audit of the environment." We provided immediate feedback about our findings in relation to the cleanliness of the home and specifically the mould that we identified during the first day of the inspection. However, when we returned to the home on the second day of our inspection no action had been taken to remove the mould or to complete a deep clean of the home.

In addition to the concerns that we identified in relation to the cleanliness of the home we observed that fire doors were wedged open throughout the home. The provider had not identified this practice nor considered that the failure of a fire door to close would pose a significant risk of harm to people living in the home in the event of a fire.

The provider had not implemented any system to audit the records of people's care and therefore had not identified that they needed to review the way in which they were supporting people to partake in meaningful activities. The levels of participation in activities had reduced in July and August 2017, this had not been identified by the provider.

This inspection also identified an on-going breach of regulation 11. The provider failed to implement systems to ensure that they were fully meeting the requirements of the MCA and to ensure that the care and support that people received did not infringe upon their right to make decisions.

St Michaels House was inspected by CQC in May 2016 and we found that the provider was in breach of regulation 17 (1)(a) and (2)(b), we inspected the service again in April 2017 and found that the provider remained in breach of regulation 17 (1)(a) and (2)(b). During this inspection the provider, for the third time, remains in breach of regulation 17 (1) (a) and (2)(b) because systems to monitor and improve the quality of care and support that people receive have not been implemented consistently, systematically or appropriately. This consistent failure in the leadership and governance of the home has contributed towards the rating of inadequate in the well-led domain.

The failure to address on-going breaches of regulation, implement a system of quality assurance or to identify and address the shortfalls in the cleanliness and suitability of the premises constitute an on-going breach of Regulation 17 (1) (a) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014, Good Governance.

During this inspection we identified that the environment continued to require redecoration and that the furniture both in people's bedrooms and in the communal areas of the home continued to require replacement because they were damaged. The provider sent us an action plan in August 2017 detailing the improvements that they intended to make however, these had not been made in a sufficiently timely manner. The provider told us that the refurbishments to the home would start at the end of September.

For example, the furniture in one bedroom, which was shared by two people was broken. The headboard on one person's bed was not fully attached and wobbled. The carpet on the stairs was loose and posed a hazard to people using the stairs to access their bedroom. Two bathrooms did not have a lock on to maintain people's privacy. Carpets throughout the home were soiled with ingrained dirt and debris that had not been cleaned.

This constituted a breach of Regulation 15 (1) (a) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and Equipment.

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 House. During this inspection we found that the provider had taken some action to lever change at St Michaels House. Staff had been provided with training in person centred care to try and re-focus the culture within the home from providing task based care. Systems had been developed to seek feedback from people living in the home and a programme of activities had been introduced. These actions, although positive, require further development to ensure that they are sufficiently embedded in practice and are working successfully to improve the experience for the people receiving care and living at St Michaels House.

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.

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 imposed a condition of registration to require the provider to provide evidence of how they were following the principles of the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure that the home was kept sufficiently clean and that action was taken to protect people from the risk of harm through the spread of infection was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We imposed a condition of registration to require the provider to consider the cleanliness and suitability of the environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment During this inspection we identified that the environment continued to require redecoration and that the furniture both in people's bedrooms and in the communal areas of the home continued to require replacement because they were

damaged. This constituted a breach of Regulation 15 (1) (a) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and Equipment.

The enforcement action we took:

We imposed a condition of registration to require the provider to consider the cleanliness and suitability of the environment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to address on-going breaches of regulation, implement a system of quality assurance or to identify and address the shortfalls in the cleanliness and suitability of the premises constitute an on-going breach of Regulation 17 (1) (a) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

The enforcement action we took:

We imposed a condition of registration upon the provider to require them to introduce a system of quality assurance and for them to provide monthly reports to the Commission in relation to their quality assurance audits.