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St Michaels House

Inspection report

1-3 St Michaels Avenue
Northampton
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Tel: 01604250046

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
St Michaels House is a residential care home registered to support up to 13 adults with mental health conditions and/or people who misuse substances. There were nine people living at the home at the time of inspection.

People's experience of using this service and what we found
People were satisfied living at the home and felt they received adequate care. However, there were continued failings in relation to the management, governance and oversight of the service.

The management team had failed to take sufficient action to make improvements from the previous inspection. The management team had been unable to implement effective governance structures to adequately review people's care.

The management team had insufficient oversight of people's care plans and risk assessments, and the audits that were in place were ineffective at identifying where improvements were required.

The management team did not ensure adequate records were maintained in relation to the care people received and had failed to audit key documents in relation to this.

The management team had an inadequate understanding of their role in ensuring, and reviewing, that people received the care they required. They failed to understand the requirements of how to run a Good service.

People did not have all the risk assessments they required to reduce their known risks. For example, one person at risk of malnutrition did not have a risk assessment in place giving guidance to staff to minimise this risk.

Since the last inspection the provider had introduced some personalised risk assessments however they were not regularly reviewed or updated when changes to people's care needs had occurred.

Sufficient arrangements were in place to support people with their medicines and there were enough staff to support people safely. Adequate cleaning arrangements were in place.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 5 March 2020) with well led rated

inadequate and the service placed in Special Measures.

At our last inspection we found breaches of the regulations due to our concerns about the leadership of the service and insufficient risk assessments in relation to people's care. The provider met with us after the last inspection to tell us what they would do and by when to improve. In addition, they have been required to submit monthly reports to the Commission outlining the improvements they were taking.

Not enough improvement had been made at this inspection and the provider was still in breach of the regulations.

This was a continued breach of Regulation 17 (Good governance) and Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service remains in Special Measures.

Why we inspected
We carried out this focussed inspection to follow up on the action we told the provider to take at the last inspection.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions and therefore we did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvement.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Michaels House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have found breaches in relation to insufficient risk assessments relating to people's care and insufficient leadership, oversight and governance of the service.

We will update the end section of this report to provide information about CQC's regulatory response to the breaches found. We will do this once any action has concluded.

What happens next?
We are continuing to keep the service in special measures as we have rated it inadequate in a single key question over two consecutive inspections. This means we will keep the service under review and if it is still operating, will re-inspect within six months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means that if we have not already done so, we will start processes that will prevent the provider from continuing to operate the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

St Michaels House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

Service and service type
St Michaels House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

The service had a manager registered with the Care Quality Commission. Registered managers and providers have legal responsibilities for how they run the service and for the quality and safety of the care provided.

Notice of inspection
Due to COVID-19, we telephoned the service immediately before we entered the home. This was to ensure we had appropriate personal protective equipment for the inspection.

What we did before the inspection
We reviewed the information we had about this service which included safeguarding information and statutory notifications the service had submitted. We used all this information to plan our inspection. We did not ask the provider to complete a Provider Information Return prior to this inspection. This is information

we require providers to send us annually following their first inspection to give us some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who lived at the home and two members of care staff. We also spoke with the acting manager and the provider.

Requires Improvement

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 requires improvement. The rating for this key question has remained requires improvement.

This meant 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.

Assessing and managing risks
At our last inspection the provider had failed to ensure people had personalised risk assessments which were reviewed regularly. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Since the last inspection, some action had been taken to identify people's risks and implement a risk assessment however this had not sufficiently identified all of people's risks.
- For example, one person at risk of depression, one person at risk of malnutrition and one person at risk of behaviour that may harm themselves or others did not have risk assessments in place to identify what strategies could be used to mitigate these known risks. This put people at risk of receiving unsafe and inconsistent care.
- The risk assessments for people's care that were in place were not regularly reviewed or updated when changes had been made. For example, one person at risk of falls did not have their risk assessment updated following a fall. There was no information regarding the fall or any further review of their care to help prevent this. This meant staff may not know what strategies to implement to protect the person from falling again.

People were placed at risk of harm as adequate systems were not in place to assess, monitor and review the potential risks to people's care. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
- Since the last inspection, improvements had been made to how accidents and incidents were recorded. However, follow up action was inconsistent, and people were not always appropriately checked after an incident.
- Improvements were required to ensure that following an incident, people's care plans and risk assessments were reviewed and updated to provide further guidance to staff.

Preventing and controlling infection including the cleanliness of premises
- People were satisfied with the cleanliness of the home and the support staff provided in relation to this.

One person said, "They [the staff] come and clean my room and sink every day, I sort my bed out."

● Staff wore appropriate Personal Protective Equipment (PPE) around the home, however improvements were required to ensure this was disposed of correctly and in line with government guidance.

● Cleaning procedures had been improved in light of Covid-19. There was a regular cleaning regime in place and high touch areas including light switches and door handles were cleaned at a higher frequency.

Safeguarding people from the risk from abuse

● People told us they felt safe at the home. One person said, "They [the staff] help me when I need them."

● Improvements had been made to safeguarding procedures. The provider had a safeguarding policy in place.

● The registered manager understood that all safeguarding's must be reported to the local authority and the Care Quality Commission however no safeguarding incidents had occurred since the last inspection.

Staffing; Recruitment

● People told us staff were available when they needed them. We saw that staff were task focussed and did not spend quality time with people. This meant people often spent time with little interaction with others and were left to entertain themselves.

● There were adequate numbers of staff on duty to support people safely.

● Appropriate recruitment procedures were followed to ensure staff of suitable backgrounds were recruited.

Using medicines safely

● People told us they got their medicines when they needed them. One person said, "I get my paracetamol when I need it, well every 4 hours if I need it."

● Medication Administration Records (MAR) were completed appropriately and recorded the medication people received.

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.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to implement a culture that was person centred, identified risk, reviewed the quality of care, was honest and transparent when something went wrong, engaged people within the service, worked in partnership with others and had strong leadership with strong values. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managing the quality of the service, meeting legal requirements and staff and managers being clear about their responsibilities

- At the last inspection we identified significant concerns regarding the ability of the provider to run a good quality service. This is now the eighth inspection in which the provider had failed to achieve a rating of 'Good' or above and our concerns regarding the provider remain.
- The provider had no systems in place to hold the registered manager, or the management team to account. Neither the provider nor registered manager had the competency or skills to adequately run a well led service.
- Following our last inspection, the management team had attempted to introduce an auditing system. However, this was insufficient; it did not adequately review the quality of the care people received.
- The auditing systems had failed to adequately review people's care plans and risk assessments and identify the failings contained within them. For example, risk assessments were missing, irregularly reviewed and contained insufficient guidance for staff.
- The management team lacked an understanding, the skills and ability to effectively manage and implement an effective quality assurance system. Opportunities to develop the service were missed, for example, by seeking good and outstanding services to learn from.
- The management team failed to have oversight of people's care records. For example, one person needed to have their food intake monitored to support them to gain weight. There was no oversight of this and on several occasions the records failed to show that the person had sufficient nutritional intake. This appeared to be a records issue however there was no management of this.

Leadership vision, values and culture; Working in partnership with others; Engaging and involving people

using the service, the public and staff

● The leadership was inadequate at promoting a person culture within the home. The culture and ethos of the service was task orientated. People lacked support to be engaged and live fulfilled lives.

● People spent time playing games or watching television alone with little interaction or involvement from staff. Some people were supported to go out in the community at their request however, this was monotonous and was largely focussed around necessity shopping.

● The management team had failed to engage and seek opportunities to improve with the support of the local authority, or other community groups. There was no partnership working and no significant efforts to identify best practice.

Continuous learning, innovation and improving the quality of care

● Following the previous inspection in which the service was placed in Special Measures the management team sought limited opportunities to improve.

● We found the same concerns despite assurances and evidence submitted to the Commission that adequate systems were in place.

● There was no action plan or strategic approach to how the service would improve.

People were placed at risk of harm as adequate systems and processes were not in place to assess, monitor and improve the quality and safety of the care provided. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Acting with honesty and transparency if something goes wrong

● The management team told us they understood the duty of candour responsibilities. The duty of candour is a legal duty for providers to act openly and honestly, and to provide an apology if something goes wrong.

● There had been no incidents meeting the requirements for the duty of candour.

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 12 HSCA RA Regulations 2014 Safe care and treatment People had insufficient risk assessments in place to meet their needs, risk assessments were insufficiently completed and insufficiently reviewed.

The enforcement action we took:

We restricted new admissions into the home without prior permission from the Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The leadership was inadequate, ineffective governance systems were in place and the culture throughout the home was insufficient.

The enforcement action we took:

We restricted new admissions into the home without prior permission from the Commission.