Imperial Healthcare (UK) Ltd

St Michael's Rest Home

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 27 July and 3 August 2017was unannounced. St Michael's Rest Home provides accommodation and personal care for up to 27 older people, some of who may have a diagnosis of dementia or a mental health condition. At the time of inspection there were 25 people using the service. This was the first inspection since the owner of the home changed their legal entity from a partnership to a limited company.

A manager had been appointed one month before this inspection and was in the process of applying to register with the CQC as the registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Although everyone had an up to date care plan, not all of the relevant information about each person was included in their records. Some people had a mental health condition which was not recorded, and which staff did not understand. There was no information for staff, or risk assessments in place to keep people safe and to make sure their mental health needs were met.

Recruitment practices were not robust and there were some gaps in pre-employment checks, such as full employment history. Staff knew how to recognise the signs of abuse and that they should report any concerns they may have to the manager. There were enough suitable staff on duty to meet people's needs and keep them safe. People's medicines were managed safely.

The provider's quality monitoring system was not always effective. Although the provider and manager were completing quality monitoring audits, they were not always identifying areas for improvement. The manager had been in post for one month at the time of the inspection, and had already noted areas for improvement at the service, and had a robust action plan in place, to make sure those improvements were made.

Although staff were caring most of the time, people's privacy and dignity was not always protected. People had developed positive relationships with staff and there was a friendly and relaxed atmosphere in the home. People were supported to remain independent and do the things that were important to them, such as going to the shops.

The providers quality monitoring processes were not always effective. The manager had identified this and understood what action they needed to take to make sure this area of practiced improved. The provider asked for feedback about the service from people and staff. Any feedback received was acted on where possible. There was a complaints procedure in place and the registered manager and staff knew what they should do if anyone made a complaint.

The manager had a good understanding of the Mental Capacity Act (2015) and understood that some

people living in the home did not have the capacity to make some decisions about their care. Some of the staff needed further support to make sure they understood their responsibilities under the Act. All of the relevant DoLs had been applied for, and where these had been authorised, the conditions of the DoLs were properly recorded and acted on.

People were well supported to eat and drink enough. Food was homemade and nutritious and people were supported with healthy eating and to maintain a healthy weight. Everyone was supported to maintain good health and appropriate referrals were made to health care professionals when required.

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. Recruitment practices were not robust, and the provider had not made sure all of the relevant checks were completed before staff began work.

Some risks to people's safety had not been assessed, and risk management plans were not always in place, although there were areas of good practice.

Staff knew how to recognise the signs of abuse and what they should do to keep people safe. People's medicines were safely managed and there enough staff on duty.

Is the service effective?

Requires Improvement

Although staff received training in all of the relevant areas, it was not always effective and there were some areas of practice, such as moving and handling that required improvement.

The manager had a good understanding of the Mental Capacity Act (2005) but other staff needed more support in this area.

People were supported to have enough food and drink although menu choices could sometimes be limited. People were well supported to maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring. Although there were occasions when staff were kind and friendly, people's dignity was not always protected.

People were supported to maintain relationships that were important to them and visitors were made to feel welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive. Although people's needs were assessed before they moved into the home, not everyone's care needs were identified before their care plans were developed .

People decided how they spent their time and activities were provided, but these were not always based on people's preferences.

People were given information about how to make a complaint. The provider acted on feedback when it was given.

Is the service well-led?

Requires Improvement

The service was not always well led. Although there were quality monitoring processes these were not always effective. Records were not always kept securely.

Feedback about the manager and provider was positive and the manager had a detailed action plan in place to address the concerns identified at this inspection.

St Michael's Rest Home

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 was planned to check 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. The inspection was unannounced and was the first inspection since the owner changed their legal entity.

The inspection team consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at and reviewed all the current information we held about the service. This included notifications that we received. Notifications are events that the provider is required by law to inform us of. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make

We spoke with seven people who use the service, three relatives, six members of staff, the chef, the manager, two visiting registered nurses and the nominated individual who is also the owner of the home and a director of the provider's limited company.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed the care records and risk assessments for three people who use the service, recruitment records for three staff, and the training and supervision records for all staff currently employed at the service. We reviewed quality monitoring records, policies and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives said they felt safe living in the home. One relative described how they were concerned about their family member when they moved into the home, but said "I was worrying about nothing". They felt their family member was safe because staff were, "Lovely. Smashing and very helpful" and "I'm very confident about the staff". Another relative said, "I have never had any doubts about how (name) is being looked after".

Although people told us they felt safe, we found examples of care and recruitment practices which required improvement. The provider had completed Disclosure and Barring Service (DBS) checks for staff before they began working. A DBS check is completed before staff begin work to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. However, where a care worker had declared a criminal conviction, the provider had not completed a risk assessment, to see if the conviction would affect the staff member's ability to support people safely. The manager had identified one occasion where this had happened, and had completed a retrospective risk assessment. We identified another occasion where a conviction had not been risk assessed properly. The manager took immediate action to address this. Not all of the other relevant checks were completed before staff began work, and there were minor gaps in the records. This included one care worker who did not have evidence of previous conduct where they had been employed in adult social care and a another who did not have full employment history. We discussed this with the new manager and they understood what they should do when employing new staff in the future, to make sure this did not happen again.

Risks to individuals were not always well managed. Some people living in the home had a mental health condition. Although the people were currently well, the provider had not considered the risk that their mental health may deteriorate and they may have a relapse of their mental health symptoms. Risks assessments had not been completed, so there were no risk management plans in place to make sure people's mental health and safety were protected. There was no information available for staff about how to identify if a person's mental health was worsening, or what they would need to do to support a person if they had a behaviour that made themselves or other anxious. This is an area of practice that requires improvement.

Other risks were well managed. For example, people who were at risk of a pressure ulcer had their needs assessed and appropriate management plans were put in place. The visiting community health service registered nurses confirmed such risks were well managed, and if a person had a wound, this was quickly identified. Environmental risks were well managed and the provider made sure they completed legionella, electrical equipment and fire safety checks.

There were enough staff on duty to keep people safe and meet their needs. The manager used a needs assessment tool to make sure individual's needs were matched with the right staff numbers and skill set. If people's care needs increased the manager was able to increase the number of staff on duty in a flexible way. When talking about the provider and staffing levels the manager said, "I don't have to ask, he says 'just carry on'".

As far as possible, people were protected from potential abuse. Staff and the registered manager had a good understanding of what they needed to do to safeguard people. Staff knew about the different types of abuse and were clear about how to recognise if a person was at risk. When talking about reporting concerns about someone's safety, one member of staff said, "You would have to if you've got a concern. You wouldn't be able to leave it."

However, not all of the staff knew what they should do if they were ever concerned a person was at risk. Although all of the staff we spoke with knew they should report concerns to the manager or provider, they were not always clear who they should talk to outside of the organisation if they ever needed to, such as the local safeguarding authority. This is an area for improvement.

Incidents and accidents were well reported and documented and a thorough investigation was completed for each incident. Paramedics were called or GP referrals made at the time of any incident if needed. Any themes were identified because the manager and staff knew people well, and action was taken to prevent any recurrence. For example, one person was becoming less mobile and there were concerns about the person's risk of falling. With their permission, the person moved to a ground floor room so staff could 'keep an eye' on them, to make sure they were safe. The manager and staff understood the importance of learning from incidents so they could make improvements. Staff felt confident to report incidents, and knew the manager would deal with it appropriately.

People's medicines were managed so they received them safely. Medicines administration records (MAR) showed people received their medicines as prescribed. Staff could not administer medicines unless they had been trained and had their competency assessed. There was a policy in place to support staff to safely administer medicines. Some people took medicines on an 'as and when required' basis (PRN). Every person who required PRN medicines had an assessment of their needs and a plan was in place to help staff identify when people might need their PRN medicines. There was a safe procedure for storing, handling and disposing of medicines. In June 2017, the pharmacy used by the home completed a medicines audit. Some minor areas of improvement had been identified, such as recording the application of a person's prescribed creams on a body chart. Most of the actions identified had been completed, and where they had not, the manager had a plan in place to make sure they were. This included monitoring stocks of medicines to make sure medicines were not disposed of due to overstocking.

Requires Improvement

Is the service effective?

Our findings

Although the manager had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs), some of the staff did not. This legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. Staff did not understand what capacity was and could not always explain the decision making process if a person lacked capacity. The manager was able to explain when a DoLs referral would be necessary and appropriate DoLs referrals had been made to the relevant authorities. Three DoLs had been approved and the conditions of the DoLs were recorded in each person's care plan.

Although staff were kind when talking to people, they did not always make sure they asked people for their consent before providing care. For example, at lunch time people were being supported to put on clothes protectors. The staff member said to the person, "I'm just going to put this on you", rather than asking the person if that was alright. Other staff were able to describe how they asked for people's consent and one care worker told us, "I ask all the time". Records showed people or their representative had been asked for consent for other aspects of their care, and more complex decisions were well recorded.

Although staff received training to help support them in their roles this had not always been effective. As well as the limited understanding of MCA, we also observed practice which was not as good as it should have been. For example, all staff had been trained in how to support people with moving and mobilising. One person was helped to reposition themselves in their chair. Although the person was supported in a safe way, staff did not speak to the person as they helped them to move. The person looked uncomfortable in the position they had been left in as they were slumped in the chair. We pointed this out to the manager, who took action, and the person was helped to become more comfortable.

Staff completed training in other mandatory subjects such as safeguarding and first aid, as well as dementia awareness. Staff were also supported to complete additional health and social care qualifications such as a diploma. Staff had regular supervision and appraisal. Staff said they felt well supported with supervision and were comfortable to discuss any concerns or ideas they might have. It is important to provide staff with regular opportunities for reflective supervision and appraisal of their work. It enables staff to ensure they provide effective care to people who use the service. Supervision meetings were meaningful, and topics discussed included people's care needs and goals as well as the staff member's individual work place needs.

People and their relatives gave us positive feedback about the food. One person said, "excellent food…first rate…very good selection of dishes". A member of staff said, "The food's lovely. (Name) is a good cook. They all seem to enjoy it". People were supported to have enough to eat and drink and to maintain a balanced diet. Food was homemade and nutritious and there was a varied rolling four week menu. If people did not like what was on the menu an alternative was offered and staff knew people's preferences well. For example, on the first day of our inspection, lunch was sausage casserole. Staff knew one particular person did not like this meal, so they were offered an alternative meal straight away.

Although the menus varied daily, the meal choices on the rolling menu had not been reviewed for more than a year. One person said, "Food is very good here…not given a choice in the morning," and they were, "never asked what you would like". We discussed this with the manager, who said they had plans to review the breakfast choices so a cooked breakfast was offered more frequently. The manager had already identified breakfast choices were sometimes limited, with people being served toast that was already buttered and with marmalade, rather than people being asked what they preferred. The manager confirmed they would discuss meal choices and menus with people at the next residents meeting. Staff ensured people had access to drinks throughout the day and food and fluid intake was monitored, and appropriately recorded if it were needed.

People were supported to maintain good health and had access to healthcare services. People were supported to see their GP, district nurse or mental health professional if they needed to. The visiting community registered nurses both confirmed staff made the right referrals when they needed to. A relative told us how their family member was well supported by staff to have their medicines reviewed. This had led to an improvement in the person's health and quality of life, as they had been taking some medicines they no longer needed. One person told us how they had been supported by staff to go to the dentist during the inspection. One person became unwell during the inspection. Staff took the right action quickly and reassured the person. They offered to contact the GP, but the person soon recovered and the GP was not needed.

Requires Improvement

Is the service caring?

Our findings

People were did not always have their privacy and dignity protected. We observed one person being supported to dry and style their hair after having a shower. However, the person was being supported in the lounge area of the home in full view of the other people who were sitting in the lounge eating their breakfast. The person had not been offered the privacy of their own room to dry their hair. The manager had already identified this as an area of practice that required improvement, and was part of their action plan to help improve the quality of care people experienced.

On occasions we observed staff speaking to people in a way that was not appropriate for their age. This was undignified and could have been interpreted as being patronising. We heard two staff members using terms such as "darling" when talking to people or trying to attract their attention. When we asked the staff what the name of the person was, they could not remember as they had only recently started working at the home. It is important for care workers to know each person's name, as this shows they are sensitive to the person as an individual, and focus on promoting their wellbeing and meeting their needs.

The TV and radio were on at same time and the volume was loud. Noise is a known stressor to people with dementia and every day sounds can cause people to become upset. Noise from a television or radio that is not listened to or watched, can contribute to a sense of disorientation for people. Staff did not ask people what their preference was about the TV and radio or what volume the volume should be. When we asked staff about this they were unsure why both were on, and the manager said they would review this as part of their action plan for improvements.

Some of the furniture people had to use was old, worn and dirty. Some of the seats had a faint but unpleasant smell when sat on. Lace cloth placed over the backs of some of the chairs to protect it from grease and dirt were grimy where people would rest their heads. The manager had identified the worn furniture, and had added to their action plan for attention.

We observed other occasions where staff were kind and caring when talking with people. One person told staff they were in pain. The care workers reacted quickly, and took time to comfort and reassure the person because they were upset. Staff took the right action and offered a call to the person's GP, but they declined at that time. The person shortly recovered from their pain, but staff made sure they kept an eye on them during the rest of the day. People had been supported to get dressed in a way they preferred and people were clean and well dressed.

A relative told us staff were always "kind and caring" towards their family member and "staff are very nice". Another relative described staff as "genuine and very hardworking". A visiting health care professional said staff, "Treat people like a member of the family. It's really nice to see". Another relative said the best thing about the home "is the staff. They're very jovial. Very good"

One member of staff said people, "Have independence and personalised care. We maintain their dignity". A relative described how their family member was cared for by staff who were "always laughing and happy".

They said staff understood their family member's care needs well, and if the person became anxious staff knew a walk around the home's garden would help to calm them. They went on to describe the home as "an absolutely lovely place". People were supported to maintain relationships with family and friends and visitors were able to visit whenever they wanted and were always made to feel welcome when they did.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed before they moved into the home. A relative told us this had happened for their family member and added, "I can't fault that" when talking about the assessment. People and relatives were involved in developing their care plans and the information from the assessments was used as the basis of the care plans. Care plans contained information about people's care needs, for example, what support they may need with personal care. There was guidance for staff to follow to ensure people's needs were understood and met. There was information about personal histories and people's choices and preferences.

Although people's care plans contained most of the relevant information, some did not. People who had a mental health condition did not have this properly recorded in their care plan. There was no information available for staff to enable them to meet people's care needs specifically in relation to their mental health. Some staff did not know which people had mental health needs. While there was currently no impact for people as they were all well, there was a risk that some staff would not know what to do if a person mental health deteriorated, or what they should do to make sure people remained well.

Some people were supported with individual hobbies. One person liked knitting and another gardening. However, other feedback from people and relatives about activities was there was a lack of individual activities which reflected people's preference such as puzzles or card games. We did not see any people being supported with an individual activity during the inspection. People were supported to go out to the local town for shopping, and into the wider local area to visit the seafront and countryside. People who were more independent were supported to do things on their own, such as shopping at the local supermarket.

A local pet therapy service visited the home regularly, and bought along a range of animals for people to touch and stoke. These included cats, dogs, lambs and guinea pigs. One member of staff said people "love it". Using pets and animals as therapy helps people to relax and can encourage a feeling of wellbeing for people.

The provider had an appropriate complaints procedure in place and staff knew what they should do if anyone raised a concern with them. For example, a relative described how they had been unhappy about how staff had supported their family member with personal care. They had complained to staff about this and said, "They now do regular checks. It's never happened again". The manager and provider acted on other feedback they received. For example, one person needed a specific toiletries to help protect their skin. As soon as a member of staff pointed this out, the right toiletries were purchased on behalf of the person.

Residents and staff were invited to attend regular meetings, so they could give feedback about their experiences of the service. For example, people had been asked about what they would like to do with the garden during the summer. People made suggestions such as the type of plants they would like to grow, and being able to work in raised beds. Other topics discussed included actives and meals out.

Requires Improvement

Is the service well-led?

Our findings

We reviewed the provider's quality audits. These included areas such as people' care plans, cleanliness and medicines safety. However, Some of the audits were not as detailed as they should be. For example, the health and safety audit was not clear about what was being checked, and it was a 'tick box' record. One area for safety checks was wheelchairs. The audit did not list what wheelchairs were in the home, or what staff should be checking for safety, such as tyre pressure or safety straps. The cleanliness audit did not cover all areas of cleaning around the home. We found a few areas in the home where cleanliness needed improvement, such as high level dust and dirty pull cords on toilet lights. Although this had a low impact on people, there was a minor risk the provider may not identify other areas of poor cleanliness as they were not always monitoring this properly. Effective quality monitoring audits are important as this ensures the provider identifies issues as they arise so they can take action as soon as possible.

People's care records were not always kept securely. We found a records archive which was not locked. This contained people's personal information and old care plans. The records were not secure and could have been accessed by anyone in the building. The provider was trialling a new electronic care records system. Staff used a special 'app' on a smart phone provided by the service to record what care a person had received during their day, and to check what the person's care needs were. The aim of the new electronic system was to help staff record and access the most up to date information about people, and their care needs. The electronic system could also be used to audit people's care needs, and this was the next phase of development for the service. The use of an electronic system would also reduce the need for paper records to be stored.

People and those important to them were invited to take part in satisfaction surveys and these were used to collect feedback about the support and care provided. The results were made available to people and the responses were good overall. The manager was in the process of sending a new satisfaction survey out to people, so they could continue to develop their action plan.

The new manager had only been in post for one month when we visited to inspect the service. They were open and honest, and took very active role in the inspection process. They had already highlighted all of the concerns identified at this inspection, and had a detailed action plan in place to address the issues. They had taken time to get to know people and staff, and were clear about what they needed to do to make the required improvements. Staff gave positive feedback about the new manager. One care worker said the manager was "very fair and seems really nice" and "I haven't got any worries".

Feedback about the provider and owner of the home was also positive. One relative described the provider as "very good" and they "visit regularly". They also said the provider "does work around the home and balances business and care". Staff morale was good and staff said they enjoyed working at the home. One member of staff said, "I absolutely love it here".

The manager had a clear understanding of the key challenges for the service and the action they need to take. All of the registration requirements were met and the provider ensured that notifications were sent to

us CQC when required. Notifications are events that the provider is required by law to inform us of.