

St. Michael's Care Ltd

St Michael's Home

Inspection report

251 Warwick Road
Olton
Solihull
West Midlands
B92 7AH

Tel: 01217079697

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

St Michael's Home is a residential care home providing personal and nursing care to 16 people aged 65 and over at the time of the inspection. The service can support up to 21 people. The rooms are provided over three floors with access via stairs or a lift however only the ground and first floor had bedrooms in use

People's experience of using this service and what we found

Risks to people in relation to premises and environment were not always suitably assessed, monitored and mitigated. Renewal work and repairs were not completed in a timely manner. Medicines were not always safely managed which put people at risk of harm.

The provider did not have suitable systems and processes in place to ensure areas identified for repair or improvement had been acted upon. Quality assurance systems were not robust enough to identify issues and drive improvement.

Staffing levels were adequate to meet the basic personal care needs of people however vacancies meant that staff did not always have capacity to support with activities and social events.

People said they were happy living in the home and relatives said the staff were friendly, supportive and helpful.

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

Rating at last inspection

The last rating for this service was good (published 09 May 2018).

Why we inspected

The inspection was prompted in part due to concerns received about the environment, medicines and staffing. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to the management of medicines, the environment and staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. The provider has taken action to mitigate some risks, but we are not fully assured that the actions have been effective.

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

Enforcement

For enforcement decisions taken during the period that the 'COVID-19 – Enforcement principles and decision-making framework' applies, add the following paragraph: 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 identified breaches in relation to the maintenance and cleanliness of the environment, and the lack of oversight of how this has been managed.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

St Michael's Home

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

An inspector and an inspection manager carried out this Inspection.

Service and service type

St Michael's Home is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission at the time of the inspection. A new manager had been recruited but had not started in the role. Management responsibility was provided by a manager from another location owned by the provider. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This 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 and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with five members of staff including the acting manager, senior care workers, care workers and the chef.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals who regularly visit the service.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

Using medicines safely

- Medicines were not always safely managed. Medicines were administered by staff whose training and competencies were not current. This meant that people were at risk of not receiving their medicines correctly. Staff agreed they would book training as soon as possible.
- There was no thermometer in the room used to store medicines and staff did not routinely check the room temperature. We could not be sure people had received medicines that had not been damaged due to temperature extremes. A staff member told us the thermometer had been lost and ordered one on the day of the inspection to rectify this.
- Staff did not routinely record where they had applied prescribed creams, despite a reminder at team meetings to do so. Recording applications helps to ensure staff were administering creams safely and in line with manufacturers guidance.

Assessing risk, safety monitoring and management

- Risks relating to the environment were not always suitably assessed and managed.
- The rear fire exit led into a small courtyard. The exit away from the building through a side gate was padlocked and therefore people were at risk of being trapped in this courtyard close to the building if there was a fire. In addition, the courtyard had a low hanging washing line which meant people could be injured leaving the building in an emergency. The provider told the day after the inspection that the washing line had been removed and the gate unlocked.
- The storage area at the top of the building was easily accessible to people via the stairs or lift. This area contained hazardous materials such as paint and white spirit which put service at risk of harm if ingested. One door was locked while we were onsite, and the provider told us the other door had since been locked but we are not assured this will remain secured.
- The laundry door was left unlocked when not in use by staff exposing people to potential risks from high voltage electrical boxes, laundry equipment and detergent. The provider informed us this was now locked following our visit but we were not assured this has been fully embedded into staff practice.
- The slow riser on the fire door at the bottom of the front stairs was broken which meant the door banged shut with force. As this area was regularly used by people, a number of whom were mobile, meant they were at risk of injury from this door. Staff had reported this in the maintenance log previously, but this had not been addressed, despite staff asking for this. The slow riser was mended on the day of our inspection, but we were not assured this poor maintenance will not reoccur. Other areas were hazardous due to the way the furniture had been left so that the pile could fall over.
- Equipment safety checks had not been routinely recorded as completed on the required charts. Staff therefore could not be sure the equipment used to move people remained safe to use.

- Toiletries and personal items had been left out in the communal bathrooms which could be a risk to the health of people especially those with dementia. Staff had cleared these before we left the site and the proper soap dispensers had been filled to reduce the risk to people.

Preventing and controlling infection

- Communal areas of the building including the rear stairs were visibly unclean. The carpets were worn and stained and covered in dead wasps. The cleaner had been off sick and care staff had been deployed to maintain cleanliness in peoples' personal spaces, but some areas of the home had not been cleaned for some time. Cleaning schedules had not been completed so staff did not know which areas needed to be cleaned or when they were last cleaned.
- The tables used as stations for staff to access PPE were old and damaged and we could not be assured they could be adequately cleaned to prevent the spread of infection.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- The provider had an action plan in place which included maintenance of the environment however some areas of the building were in a poor state of repair. This included rusting radiators and water damage to walls and ceiling tiles in three communal bathrooms. In the lounge and corridors wallpaper was peeling off the walls. The linen room floor was damaged, uneven and unclean. Although these were on the plan the dates for completion were such that the work should have been taking place while we were on site and it was clear the timeframe for repairs was not being followed or the plan updated to reflect this.
- Some furniture had been replaced however the old items had been disposed of in various areas both inside and outside the building. One area in particular was outside one person's bedroom window obscuring their view outside.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were not fully assured the provider was promoting safety through the layout and hygiene practices of the premises due to the condition and cleanliness of the home and the stations for storing PPE.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse

- People said they could speak to staff when they needed to. One person told us "I feel safe here."

- Staff told us about different types of abuse and knew how to report concerns.
- The acting manager ensured staff received training in safeguarding and understood their concerns in safeguarding people from abuse.

Staffing and recruitment

- Staff told us that due to staff shortages they felt unable to take annual leave as there was no one to cover their shifts for them. Some staff completed online training in their own time to keep up to date, but the training matrix showed not all staff had completed the required training. During the inspection there were enough staff to ensure people's basic needs were met and staff on duty had the experience and skills needed to support people safely.
- People said they liked the staff although one person said, "It's not great here, like it used to be, they need more staff."
- The provider ensured new staff received all appropriate checks and an induction.

Learning lessons when things go wrong

- Staff recorded incidents and accidents as they happened and were clear about what they needed to report.
- The provider did not have suitable systems in place to ensure lessons could be learnt when things went wrong. For example, there was no analysis of incidents such as falls to ensure the necessary actions were taken to reduce the risk of them happening again.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The home did not have a registered manager. A new manager had been recruited and was due to start once all relevant checks had been made. A manager from another home was covering but was unable to be on site full time.
- The provider failed to ensure effective systems were in place to continually assess, monitor and improve the quality and safety of the service provided. The quality and effectiveness of the audits were not reviewed and there were no systems in place to identify the issues we found during the inspection or to drive improvement.
- The provider lacked oversight of audits relating to the environment. This meant actions had not been taken or reviewed to ensure the environment was fit for people to live in. The provider failed to take responsibility for this when the registered manager left their role. Maintenance plans for the environment and checking of equipment were not robust.
- Staff said they did not know if vacancies had been advertised or new staff recruited which was not good for morale within the team. The acting manager responded that this had been discussed in team meetings but we did not see evidence of this during the inspection.
- The provider had failed to implement quality assurance systems around medicines management. The provider failed to ensure staff had understood their responsibilities for completing records or ensuring medicines were stored safely.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- People and their relatives were happy with the care provided by staff. One relative said, "Staff are helpful, polite and caring towards [person's name]."
- Staff knew people well and considered their preferences and wishes while offering personal care. They described people as being "like family" and wanted to do the best they could for them.

- The acting manager and staff communicated with relatives and let them know when things went wrong. One relative said, "The carers are professional and keep me informed of all [person's name] needs and report to me any concerns they have."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- One person said they preferred to get up very early as this was part of their working life and staff always went to them first to ensure this happened.
- Relatives said staff were aware of people's needs and considered this when care was being delivered.
- Staff had recently completed surveys with people about their personal space and how they would like this to be decorated. The provider had agreed to implement this although work had not started.
- The provider had ensured menus reflected the choices of people and special diets and cultural needs were considered and respected.

Working in partnership with others

- Records showed staff liaised with a range of professionals such as the GP and district nurses when needed to ensure people received appropriate help and support.
- The local authority told us they were working closely with the provider on a range of actions following concerns they had identified.

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	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider did not ensure the environment was properly maintained to keep people safe. This was a breach of Regulation 15(1)(2)

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider failed to ensure environmental risks were suitably assessed and managed, that medicines were safely managed and the premises were always safe.</p>

The enforcement action we took:

We issued a warning notice. This notice requires the provider to become compliant with this regulation within a given timeframe. If the provider fails to become compliant, we may take further action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not have robust quality monitoring systems and processes in place to ensure they continually evaluated the service and make the required improvements.</p>

The enforcement action we took:

We issued a warning notice. This notice requires the provider to become compliant with this regulation within a given timeframe. If the provider fails to become compliant, we may take further action.