St. Michael's Care Ltd

St Michael's 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 18 May 2016 and was unannounced.

St Michael's home is a residential care home providing care and accommodation for a maximum of 21 people. At the time of our visit, the home was fully occupied.

The service did not have a registered manager. 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. Since our inspection in August 2015, the registered manager left, and the new manager started working at the service six months ago. They had not applied to be registered with the CQC.

At our last inspection there was breach in Regulation 11, Consent to care. During this visit we checked improvements had been made. We found most people were able to make day to day decisions, and staff understood how to make decisions in a person's best interest. Applications for Deprivation of Liberty safeguards (DoLS) had either been made, or were in the process of being made to the local authority, when people had been deprived of their liberty. However, the manager acknowledged they and their staff would benefit from further training about the Mental Capacity Act and DoLS.

There were insufficient audits in place to enable the provider and manager, identify where quality and safety was being compromised, and to respond to appropriately. There was no record of meetings attended by the provider to determine how the home was meeting its requirements under the Health and Social Care Regulations.

The manager had worked hard to update people's care plans and risk assessments. However, not all care plans and risk assessments reflected people's current needs, and inconsistencies were identified during our visit which might put people at risk. Subsequent to our visit, a serious incident happened at the home. Whilst an investigation into this incident is on-going, initial findings indicate that the risks associated with this person's care and support were not managed safely.

People received their medicines as prescribed, but medicines were not always kept secure from people and administration not always recorded correctly.

There had been issues with staff leaving their employment and the use of agency workers to cover staff shifts. This was being rectified and the use of agency staff had reduced. There were enough staff available to meet people's needs. Recruitment practice reduced the risks of employing unsuitable staff at the home.

There had been concerns raised about people not receiving the food and fluids necessary to keep them healthy. This was because the cook had left their employment, and food and fluid monitoring was

inadequate. We found improvements had been made but there were still concerns about the records kept in relation to this. A cook was in place and people told us they enjoyed their meals..

Staff were caring towards people, and respected their dignity and privacy. People were supported to pursue their hobbies and interests and maintain relationships with people important to them.

People told us they felt safe living at the home, and the manager worked with safeguarding authorities when there were concerns about people's safety. Staff understood their responsibilities to safeguard people who lived in the home. Health care professionals were involved when necessary to provide healthcare support to people.

The manager had worked hard to improve the quality of care provided by staff. They supervised staff, observed staff practice, and worked alongside staff to ensure good care was provided. They had increased the number of staff working on the morning shift to provide better care for people. However, staff had not undertaken all training the provider considered essential to meet people's health and social care needs.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

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 mostly safe.

The risks to people's health had been assessed but risk assessments were not always up-to-date, and some included conflicting information. We could not be assured that the risks associated with people's care were always managed safely. People received their medicines as prescribed, but medicines were not always kept secure from people and administration not always recorded correctly. There was sufficient staff to meet people's needs, and recruitment practice reduced the risks of employing unsuitable staff.

Is the service effective?

Requires Improvement

The service was mostly effective.

People's consent to care was always requested before care was given. Deprivation of Liberty Safeguards, were in place for some people, and the local authority had been approached about others. Staff had received some training the provider considered essential to meet people's health and social care needs, but not all. Staff received support from the manager to provide effective care to people. People were supported to have a nutritional diet and enough to drink, however improvements were needed in the monitoring and recording of this. People accessed health care services.

Is the service caring?

Good

The service was caring.

Staff were caring in their approach and interacted well with people. There were now positive relationships between the people who lived in the home and the staff supporting them. People's privacy was respected and staff promoted people's independence and dignity. People were encouraged to maintain relationships with people important to them.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

Care plans were written, but they were not always up to date, or provided staff with consistent information. Staff supported people to maintain their interests and hobbies. People and relatives felt they could approach the manager if they had any concerns and action would be taken. No formal complaints had been made in the last 12 months.

Is the service well-led?

Requires Improvement

The service was mostly well led.

Effective systems were not in place to monitor the quality and safety of service provided. The manager had worked at the service for six months. Staff felt supported and listened to by the manager and people told us the manager had improved the quality of care provided by staff at the home. The manager had not applied to be registered with the CQC. People's views on the service were sought and listened to.

St Michael's 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 took place on 18 May 2016 and was unannounced.

Two inspectors and an expert-by-experience conducted this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at information received from statutory notifications the provider had sent to us, and contacted commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or the NHS. The local authority commissioners shared with us some concerns about the quality and safety of the service provided.

We spoke with eight people who lived at the home, two visitors, and seven staff members. We also spoke with the cook and the manager. We spent significant periods of time observing the care provided in the lounge and other communal areas.

We reviewed four people's care records to see how their care and support was planned and delivered, and looked at the medicine administration records. We looked at other supplementary records related to people's care and how the service operated. This included checks management made to assure themselves that people received a good quality service.

Requires Improvement

Is the service safe?

Our findings

The manager had assessed risks to people's individual health and wellbeing. Some risk assessments explained to staff what the risks were to each person and the action they should take to minimise the risks. For example, where people could not move on their own, the risk assessments told staff the actions they should take to reduce the chances of the person being at risk. This included using a particular type of hoist and the number of staff who needed to assist in its use.

However, the information included in risk assessments was not always current, and sometimes did not reflect the practice seen in the home. For example, one person was assessed as at high risk of falls, their risk assessment stated they could not walk more than a few steps with their frame, requiring the support of one member of staff. We saw the person walked more than a few steps, and without assistance of staff for some of the time. The manager told us the person's mobility had improved, but this had not been updated in their care plan. The same person's risk assessment identified that they should have a pressure sensor mat when they were in bed so staff could be alerted to them moving out of bed. There was no pressure mat in their room during our visit. The manager told us they would take action to address this.

We saw other examples where care plans and risk assessments provided conflicting information. For example a care record informed us that the person required only one member of staff for support, but in another part of the record, informed us the person required two staff for support. After our visit, a serious incident occurred at the home. Whilst an investigation into this incident is on-going, initial findings indicate that the risks associated with this person's care and support, were not managed safely.

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

We discussed our concerns about people's risk assessments and care plans with the manager and they accepted that care plans and risk assessments needed updating. They told us they had recently re-written all of the care plans, and accepted they required further improvement. They told us they had started to delegate the task of monthly checks of care plans to senior care workers to make sure they were accurate. A senior care worker confirmed to us that the manager had asked them to check specific care plans to ensure they were up to date and accurately portrayed the needs of people.

Prior to our visit we had been made aware there had been staffing concerns at the home. This was because a number of staff had left their employment at the home within a short space of time, and two had been dismissed for poor practice. The manager had filled their hours with agency staff until new staff had been recruited. At the time of our visit the manager had recruited to most of the vacancies and the use of agency staff had reduced.

People who lived at St Michael's had mixed views about the staffing levels. Some felt there were sufficient staff to meet their needs, whereas others thought there were times when there were not enough. For example, one person said, "I don't think that there is enough staff, they are a bit run over at times, you ask

for something and they say that they will be back in a minute or two and they sometimes take a while."

Staff told us when they were fully staffed, there were sufficient to meet people's needs, however when staff phoned in sick at the last minute this could present problems. One member of staff told us, "It can get hectic here, there is a lot of staff sickness that we have to cover and it's hard. People still get the best care though; we will stay over to cover empty shifts." Another said, "We are short staffed, one person walked out last week, we cover shifts and sometimes use agency, and we did the other day, but not that often." The manager confirmed there was an issue with staff sickness but this was being addressed.

Staff also told us the manager had increased staff numbers in the morning after it had become clear that people's needs were not being met. They told us this had helped provide safer care because one member of staff focused on making sure medicines were administered to people, whilst other staff had time to help people have their breakfasts and provide personal care. On the day of our visit, no one was absent due to ill health, and we saw sufficient staff on duty to meet people's needs.

Since our last inspection, not all people had been protected from abuse. A person told the manager of an incident that made them feel unsafe. This incident happened prior to the manager coming into post. The manager took immediate action to ensure the person was safe and contacted the safeguarding authorities who conducted an investigation. The person told us they now felt safe at the home. There had been other safeguarding concerns. We spoke with the safeguarding social worker who informed us the manager had supported them with their investigations. We asked other people who lived at St Michael's Home, whether they felt safe. They told us, "I am perfectly happy here and completely safe". And, "I would not be [safe] anywhere else, I am completely satisfied and I hope that I can stay here until I pass away."

The manager notified us when there had been any concerns raised about the safety of people. However notifications did not always provide us with sufficient information. This meant we had to contact the manager to provide further information to be able to assess whether the right action had been taken at the right time. We discussed this with the manager, who said they would provide more detail when notifying us in future.

Staff recently had their knowledge about safeguarding refreshed with further training. Staff demonstrated to us they understood their responsibilities and the actions they should take if they had any concerns about people's safety.

The administration of medicines was mostly managed safely and people received the medicines prescribed to them. One person told us, "I get my medicines regularly, they never miss them." We checked medicine records to see whether staff were accurately recording medicines administered. Most medicines were recorded as given correctly, however when we looked at the administration of stronger medicines there was a discrepancy in the controlled drug book. Records between the number of medicines in stock for one person did not correspond with the number of medicines recorded as administered. We found this was a recording error, and the person had received their medicines as prescribed.

The senior care worker who administered people's medicines was seen doing so in an unhurried way. They took their time, and checked people wanted their tablets before giving them. We saw one person refuse to take their medicines and these were correctly disposed of, and recorded in the medicine record. However, we saw the senior care worker left the medicine trolley unlocked with the doors shut, and left the packs of medicines unattended on the top of the trolley. This could have potentially put people at risk. It was addressed with the care worker at the time of our visit.

The medicine records detailed people's medicine allergies to reduce the risks of staff administering medicines which would harm them. The records contained a photo of the person to reduce the risk of staff administering medicines to the wrong person. Some creams were prescribed on an 'as required' basis. We found no medicine plans (protocols) to inform staff when they needed to administer the creams, and on what parts of the body. One person was prescribed 'patches' to relieve pain. There was no pain monitoring chart to determine whether the patches reduced the person's pain sufficiently to meet their needs.

The manager told us the pharmacist visited the home every month to audit medicines. They did not leave a written report, and the manager did not undertake their own audit of medicines. As such we were unable to see how well medicines were being managed and what action was taken if errors had occurred. The manager told us they would introduce a medicines audit.

Accidents and incidents were logged and appropriate action was taken at the time to support the individual and to check for trends or patterns in incidents which took place. For example, one person had been getting blood blisters on their knee as a consequence of how staff moved them with a hoist. Staff had received further training to make sure they moved the person safely. The manager had monitored falls, and had set up a protocol (plan) for staff to follow when a person fell.

People were protected by the provider's recruitment practices. The registered manager checked staff were of good character before they started working at the home. We looked at the recruitment records of two staff. The registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions.

Some of the bedroom decoration and furniture was not in good condition. The manager informed us the provider had an action plan to redecorate and refurbish two of the bedrooms in June 2016; and one or two bedrooms a month thereafter, dependent on occupancy. A new 'quiet' lounge had been created and people were seen to enjoy using this.

Necessary equipment was used to reduce people's risks. There were a number of people who lived at St Michael's who were at risk of skin damage through putting pressure on their skin and developing pressure sores. Staff knew the people who were at risk, and made sure when people moved, their pressure relieving cushions went with them to the next chair they were sitting in. People at risk of skin damage also had the correct mattresses on their bed to reduce the chances of skin damage occurring. Hoists were used where people required support to move, and these were clean and in good order. The home mostly made good use of alarmed mats for people at risk of falls. These were placed either on the person's bed or on the floor of the bedroom, so when a person put pressure on the mat, staff were alerted the person was moving, and could check they were safe.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 18 August 2015, the registered manager had not undertaken mental capacity assessments of people who lived at the home who lacked capacity to make certain decisions themselves. This meant the home had breached Regulation 11 of the Health and Social Care Act 2008.

During this visit we checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that improvements had been made. 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.

Staff told us that whilst some people who lived at the home had dementia, they were able to make most of the day to day decisions for themselves. Formal assessments for best interest decisions had not been made. However staff told us they knew people's needs and when to make best interest decisions on their behalf.

We saw staff support people to make choices in their best interest. For example, one person had spilt liquid on their clothing. Staff asked the person if they would mind if they took them back to their room to have their clothing changed. The person refused. After unsuccessfully trying to encourage the person to move, staff left the person for a little while before going back with another member of staff who was able to get the consent of the person to assist them. Staff were aware they had the right to make informal best interest decisions, if a person's refusal to do something put them at risk. A member of staff told us, "I will try to persuade and sometimes a change of face helps, it lets someone calm down. I would report continual refusal, you can't force someone, and I know we can make best interest decisions for people".

Staff were aware of the importance of seeking consent from people. Throughout the day we saw staff check that people gave their consent before any action was carried out. Staff understood the importance of conveying information in a way that supported people to help them make decisions. A member of staff told us, "It's the way you approach someone, I try to talk slowly and explain. Its people's right to choose, after all this is their home."

People can only be deprived of their liberty to 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). Appropriate applications had been made to the supervisory body, and two people who lived at the home were safeguarded with a DoLS. These applications were made before the manager came into post. We discussed whether other people, who had moved into the home more recently, and been identified as lacking capacity would be free to leave the home. The manager told us there were three people who had not shown an interest in leaving the home, but if they did, would be stopped by staff, in order to maintain their safety. They agreed to contact the supervisory body to check whether a DoLS application was necessary. After our visit, the manager confirmed this had been done.

The manager acknowledged they would benefit from further training in the MCA and DoLS.

Staff had not received all the training they needed to meet people's needs. Staff told us they had recently undertaken training to refresh their skills in moving people and safeguarding people. People confirmed that staff used this training effectively. One person said, "Two people move me with the hoist, they get training to make sure I am safe, and I do feel safe." We also saw people being moved safely. Another person said, "I have a shower twice per week, more if I want, I feel very safe when the staff assist me, they are very careful."

However other training the provider considered essential to meet the health and social care needs of people had not been provided. A relative told us, "Staff are very good but some of the young ones don't quite know what they are doing." The manager was aware staff training was not up to date and told us the provider was setting up an on-line training system to provide staff with the training they required. They also worked with staff and provided guidance if they saw staff required extra support or knowledge.

Some staff did not know how to fully support people who were either at risk, or had damage to their skin caused by pressure ulcers. They understood how to use equipment to reduce the risks of pressure damage, but did not always understand how to prevent pressure damage occurring in the first place. The district nurse we spoke with told us a person had a 'trauma wound' because a member of staff had been too rough with them when providing personal care. However, they told us that pressure area care was improving. They said staff were undertaking two hourly continence pad changes as required and, "There are some motivated enthusiastic staff who like to learn…Some staff will go that extra mile for people". The manager was aware of the need for further staff training in pressure area care and had been trying to access this for staff.

We asked how staff, when they first started work at the service, learned about the home and the needs of people who lived there. The manager told us staff had an induction period which included reading the provider's policies and procedures, and working alongside experienced staff at the home for a period of three days. The manager told us none of the staff who had been recruited were new to the care sector. The manager was not aware of the introduction of The Care Certificate in social care. The Care Certificate was implemented to support new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. The manager informed us they would make sure any staff new to care, undertook training to receive the Care Certificate.

Staff received on going help and support from the manager. The manager had set up formal, one to one, staff supervision meetings. Staff told us they found the meetings useful. One said, "I am having my supervision today, you can discuss private things and any concerns you have." Another told us, "I get supervision every two months. We talk about why we are here, what training we need, and if the manager thinks we are weak in any area she discusses this."

Staff told us they felt able to go to the manager about any issues they had, and felt the manager provided them with informal support as well as formal support. During our visit we saw the manager observe staff practice and intervened when they felt staff could improve their practice. For example, we saw one person was moved in a hoist to an armchair. The manager was not satisfied the person had been positioned correctly and asked the staff to re-position them.

We looked at whether people received food and drink which met their needs. We were informed that prior to our visit, the cook had left the home without giving the manager time to find a replacement. This led to a lack of continuity of staff working in the kitchen, as well as staff who did not always have the relevant qualifications to provide food safely.

Prior to our visit we received concerns there had been insufficient assessments to determine whether people were at risk of malnutrition or dehydration. There were also concerns expressed about a lack of co-ordination between the care staff and kitchen staff to ensure those who were identified as being at risk received the extra food, fluids and nutrition required to keep them healthy. Concerns had been raised about the lack of records to check whether people had eaten or drank sufficiently, and to show whether weight had increased or decreased.

At the time of our visit, a care worker who enjoyed cooking, had, for the previous three weeks, been working as the cook. They had agreed to do so until a new cook could be recruited. The cook was in the process of gaining the relevant qualification, and there was an action plan to complete the necessary kitchen documentation. We asked people what they thought of their meals. One person told us, "The food is super; I am a fussy eater but we have choices, we never have the same thing twice. I have no complaints." Another told us, "The food is ok, we do have choices and they ask my opinion on the food." During our visit we saw people enjoyed their meals. We had also been given information from another professional who visited the service, that people had enjoyed the meals when they had visited.

We were in contact with the dietician who worked with the home. They informed us that whilst there were still some concerns at the home, they felt improvements were being made. The manager had worked with the dietician to improve risk assessments for those at risk of poor food and fluid intake. Weights were now being monitored regularly, and the cook told us they made sure people who were not eating well, received food fortified with extra calories to help them gain weight. They were also aware of people who required special diets such as diabetic diets.

People told us they received enough food and drink to meet their needs. One person told us, "We are offered drinks on a regular basis, hot and cold." We looked at the food and fluid charts. Staff documented the food and fluid consumed by all people who lived in the home regardless of whether they were identified as at risk. The fluid charts did not help give a consistent picture of how much fluid a person was drinking. This was because there was no systematic way of identifying the amount drank. Some staff were recording the volume, some were recording 'tea' or 'juice'. There was no total amount of fluids to aim for, and no totalling of fluids to determine whether the person had received sufficient fluid for the day.

People received support to maintain their health and wellbeing. People saw other health and social care professionals when necessary to meet their physical and mental health needs. One person told us they recently had a chest infection and said, "They got the doctor out to me really quickly." On the day of our visit we saw the chiropodist visit a person, and the district nurse visit to support people with wound dressings and to check skin damage. A person told us, "If someone had a problem, they are very good at getting an ambulance quickly or a doctor."

Good

Is the service caring?

Our findings

At our visit we saw people were treated with kindness. One person told us, "The staff here know what they are doing and know how to look after me." Another said, "The staff do the things that you want them to do, they are very caring."

The manager told us when they started work as manager of the home, they found some of the staff team were not caring and had the wrong attitude for working with people. They told us they had made sure staff knew what the expectations were in terms of caring, and some staff had left their employment at the home in response to this. A person confirmed this and told us, "Staff are getting better, previous ones couldn't care less and some used bad language." A written compliment by one of the people who lived at the home said, "[Manager's name] since you arrived there has been a lot of improvement in the care of residents, staff seem to care more and the home is calmer."

Throughout the day of our visit, we saw staff treated people with dignity and respect. For example, one person was unhappy that mealtime had been delayed. The manager acknowledged their annoyance and apologised for the delay, and explained why they had to wait.

Practical action was taken to relieve people's discomfort and retain their dignity. For example, one person required the use of a hoist for moving. Once the person had been seated, staff checked and repositioned clothing to make sure the person's dignity was maintained. Call bells were responded to quickly, and where people had accidentally spilt their drinks onto their clothes, they were changed before any discomfort was felt.

Care plans also reminded staff how to support a person with dignity and maintain their privacy. For example, one person's care plan informed staff the person wore hearing aids. The care plan reminded staff not to shout at the person and if they needed to discuss something privately, they should take the person to a quiet room.

People's right to privacy was maintained. We saw staff shut bathroom doors when supporting people to use the toilet or bathroom, and when providing personal care in their bedrooms. People's privacy was also respected with regard to information on their bedroom doors. We saw people had been given a choice of whether they wanted just their bedroom number on their bedroom door, or their photo and name on the door too.

Staff spoke of people in caring way. A staff member told us, "The best thing about this job is that I get to look after people, they are like my grandparents and I want to care for them that way."

We saw people had fun with staff and there was friendly 'banter'. We arrived at the home at 7.40am and left at 6.20pm and whilst the home was busy, throughout that time we saw staff support people in a relaxed, caring and calm way, in accordance with their plan for the day. For example, during the morning, a person had a hospital appointment. A staff member went with them to provide support, and we saw the cook

prepared the person a sandwich in case they became hungry or were not back in time for their lunchtime meal.

Staff understood people's individual needs. They told us they had time to read care plans, and we saw them spend time talking with people during the day. One staff member said, "I read all the new people's care plans, they are really useful and tell us lots like 'My life' it helps to know that information."

We asked staff about the needs and preferences of different people who lived in the home. They were able to tell us about the people who lived in the home, and how they liked to be cared for. We saw staff who had worked the morning shift, handover information to staff coming onto the day shift. They went through each person's needs to inform staff of any changes they needed to be aware of when providing care for the person.

We saw people make day to day decisions, such as where they wanted to spend their day, the food they wanted, or whether to be involved in daily tasks. One person who lived in the home helped staff lay the table for mealtime because they enjoyed doing this. The manager had recently introduced a monthly meeting where care workers would check with people, the care provided was what they wanted. People were asked questions about the food, cleanliness, complaints and choices. A person told us, "I take part in my care plan and it is reviewed." One person had signed their monthly review and on being questioned about whether they were happy, said, "Yes I am, they're [staff] very helpful."

People were supported and encouraged to maintain relationships important to them, and visitors were welcomed at the home. A relative told us, "The staff are very pleasant, cheerful and accommodating they recognise me when I come in and they are approachable."

Requires Improvement

Is the service responsive?

Our findings

Care and support records detailed information from the person's perspective about how they wanted to live their lives, what they liked and did not like doing, and how they wished to be supported. One person told us, "I like my bath every night, I told them when I first came here I do that, and I get one every night." However, care records at times, provided inconsistent or dated information to staff, which meant staff might not always know how best to support the person. For example, a care plan indicated in one section that the person did not want a male member of staff to support them with personal care, but in another section said the person did not mind male staff.

We asked people whether they had choice and control over their day to day living. People confirmed this was the case. One person said, "I can go to bed more or less when I want and get up when I want." During the day we saw people had choices in relation to their meals, and where they wanted to spend their day. We saw staff being responsive to requests, and a person told us about responsiveness to call bells, "When I press my buzzer, I don't have to wait long."

Care records went into detail about what mattered to the person. For example, one person's record stated, "I would like to wear lipstick and a blusher. I would like staff to remove facial hair that has grown." We saw staff had made sure this person's wishes had been acted on.

People were supported to follow their interests and hobbies; and take part in social activities that were meaningful to them. During our visit we saw people knitting, reading books and doing word searches. We saw staff supported people to take part in games such as Connect 4, skittles and ball games. One person told us, "I like to read and I do colouring books as well, someone comes in and throws a ball. I like to go into the quiet lounge."

The manager had found out that some people liked to go into the local town for shopping, and had arranged transport to enable this to happen. Staff went with people so they could continue to do this. A person told us, "I go shopping into Solihull; they encourage me to be as independent as I can." Staff gave up their own time to volunteer to help people follow their interests.

A new lounge had been created for people. This was a quiet lounge for people who did not want to sit with the TV. People told us they enjoyed the peace of the new lounge. This had a library of books for people to choose from.

People and relatives were provided with opportunities to share their views about the service. 'Resident meetings' were now being held monthly for people who lived in the home. The notes of the last meeting in April 2016 confirmed that people felt the home was calmer and happier. During the meeting people were asked if they made their own decisions and choices. They answered 'yes' to this. One person told us, "We have resident's meetings and they listen to you. I once asked for more toilet tissue in my bedroom and it was addressed I got more toilet tissue." Another said, "I attend resident's meetings, things which are brought up are dealt with and ideas are acted upon."

The manager told us that whilst there were no relatives meetings, there was an 'open door' policy, and they were happy to meet with any relatives to discuss people's needs, or relatives concerns.

There had been no formal complaints made to the home since 2012. The manager told us they had received informal concerns but these had been recorded in people's individual care files. They confirmed they would start to record these in one file, to track whether there was any trends or patterns in concerns raised. People and relatives confirmed that informal complaints were acted on promptly. For example, one relative told us, "I had to complain a couple of times that my mum did not have her teeth in and had dinner without them. It happened about two weeks ago, and it has now been addressed it hasn't happened since." A person told us, "If I have a complaint, I would go straight to the manager, the manager is very approachable."

Requires Improvement

Is the service well-led?

Our findings

Since our last visit in August 2015, the registered manager had left the service. The current manager had been in post for six months and at the time of our visit, had not applied to be registered with the CQC.

The manager told us they were supported by the provider. They said they were in regular e-mail and phone contact with them. They also met with the provider, and a manager from the provider's other home, on a monthly basis to share experience and provide support to each other. However, the provider did not come to the home to undertake checks or to speak directly with staff or people to find out their views about care provided. There were no notes of the meetings held with the provider to find out what actions they were taking to improve the quality of care provided at St Michael's Home, or to verify issues raised.

The manager did not have written quality assurance checks for medicines or health and safety issues such as fire testing, infection control, and care planning. The lack of quality assurance checks by the provider and the manager meant we could not be certain the home was responding effectively to the changing needs of people who lived at the home, that people were safe, and that quality was being maintained. The manager and staff had not received sufficient training to support them in carrying out their roles effectively.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

The manager had a clear vision and set of values for the service. They told us about the importance of people who lived at the home being treated with respect and being valued as people. They told us, "I expect a resident to be cared for the way my family should be," and, "I expect staff to be here for the residents."

People who lived at St Michael's were happy with the management of the home. One person told us, "The manager keeps an eye on us, she's a very nice lady and approachable. She's the right person for the job." Another said, "[Manager] is lovely, she is good, she makes sure that things get done. She is very much on top of things and organised."

Since taking the position, the manager had identified concerns with regard to people's safety and concerns relating to the attitudes and behaviours of staff. They told us they had spent time improving the culture of the home. They told us people had not been happy about staff attitudes, and felt some of the staff did not put the needs of people first. A relative told us, "Since the change of manager, staff are more accountable now and have better attitude." A member of staff told us about the changes, "Staff are not as lazy. We help each other a lot more, and are more friendly with each other."

Staff were positive about the manager. They told us, "The manager is really good." Another said, "The home is managed a lot better. The shift seems smoother, not as hectic and staff are more relaxed, not on edge like before." Staff told us the manager had introduced additional staff support in the morning from 8am to 11am to ensure people received personal care, breakfasts and medication safely. They said this had been a big help to them.

The manager was visible to staff and people who lived in the home. During our visit we saw them engage with people, help staff with care, and made sure staff were attending to people's needs. The manager's office was next to the larger communal lounge. The office had a window on each wall so the manager could see the conservatory, the lounge and the hallway. They told us they took the curtains down from the window looking into the lounge and conservatory so they could observe care practice.

The manager informed us they undertook unannounced checks of staff working during the night and at week-ends. This was to ensure staff understood their roles and responsibilities, and to provide time for them to talk about any issues of concern.

Senior care workers supported the manager in their role. The seniors we spoke with were aware of their responsibilities in relation to supporting the manager and the other members of the team. Staff were supported in their roles through regular individual meetings and team meetings. The minutes of the last staff meeting showed the manager had thanked staff for their hard work, but also informed staff of work they needed to do to provide good care.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for people who lived at the home. Inconsistency in care plans and risk assessments put people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was insufficient monitoring of the health, safety and welfare of people who lived at the home. There were insufficient audits by the provider and manager to ensure the home complied with Health and Social Care Act Regulations.