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St Michaels House

Inspection report

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13 April 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place over three days on the 31 March, 7 and 13 April 2017.

St Michaels House provides accommodation for up to 12 people living with mental health needs. At the time of our inspection there were 9 people living in the home

We inspected this service in May 2016 and found identified that there was a breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was asked to submit an action plan to tell us how they would address these breaches however, did not submit this to us.

There was a registered manager in post who was also the provider of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

The provider continued to fail to implement adequate quality assurances procedures since our last inspection. This had resulted in on going shortfalls in the service failing to be identified and resolved. We also found that the home had not been adequately maintained and the provider did not have plans in place to address the maintenance of St Micheals House.

The provider continued to fail to ensure that people received their prescribed medicines safely as there were insufficient processes in place to ensure that all prescribed medicines had been given..

People's capacity to consent to their care and support had not consistently been considered by the provider. People were subject to some restrictions where their capacity to consent to the restrictions had not been assessed or processes followed to ensure that the restrictions were in their best interests.

People did not always experience positive interactions and relationships with staff. Staffing levels within the home were not always sufficient to facilitate activities or positive engagement with people.

Staff provided care that was based on mitigating known risks; however, this provided a negative culture as staff did not relate to people's strengths, interests or implement proactive strategies to engage with people.

There was a breach of four regulations which included two continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The 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.

People could not be assured that they would receive their prescribed medicines safely.

There were not always sufficient numbers of staff working within the home.

Risks to people had been assessed and staff were knowledgeable in the action to take to keep people safe.

People were safeguarded from harm as the provider had systems in place to prevent, recognise and report any suspected signs of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity to consent to their care and support was not always sought or considered when developing people's plans of care.

People received the support that they needed to maintain adequate nutrition.

Staff received on going supervision and training to ensure that they had the skills and knowledge required to support people effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always referred to respectfully and could not be assured that they would receive person centred care.

The quality of interaction between people and staff was inconsistent.

Staff ensured that people's privacy was maintained.

Is the service responsive?

Inadequate

The service was not always responsive.

People were not always supported to develop new skills or involved in developing their plans of care.

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

There were insufficient systems in place to manage complaints.

Is the service well-led?

Inadequate

The service was not always well-led.

Formal quality assurance systems had not been implemented which had resulted in on going shortfalls in the service.

The home had not been adequately maintained and strategies had not been developed to implement improvements to the decoration, cleanliness and furniture in the home.

People did not feel able to provide feedback openly and honestly about the care and support that they received.

St Michaels House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 31 March, 7 and 13 April 2017 and was initially unannounced although we told the provider that we would be visiting on 7 and 13 April 2017.

The provider was given notice of our intention to inspect on 7 and 13 April because we wanted to ensure that they would be available to speak with.

The inspection team consisted of one inspector and one 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. The expert by experience had experience of service supporting people with mental health needs.

During this inspection we spoke with the registered manager, the providers of the service, four staff and eight people who used the service. We also spent time observing the care that people received to help us understand the experience of people who lived in the home.

We reviewed the care records of three people who used the service and two staff recruitment files. We also reviewed records relating to the management and quality assurance of the service.

During the inspection we also spoke with local health and social care commissioners who were responsible for commissioning the care and support for the people living in the home.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2016 we found that the provider was in breach of regulation 12(1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not implemented systems to ensure that people received their prescribed medicines safely.

During this inspection we found that people could still not be assured that they would receive their prescribed medicines safely. Most medicines were dispensed by the pharmacy into blister packs for staff to administer. However, we found that tablets were still present in blister packs when they had been signed for by staff as having been administered to people. Other medicines had been dispensed by the pharmacy in their original packaging and there were more of these tablets held in stock than should have been present when we compared the number of tablets received to the number of tablets recorded as having been administered. We could not ascertain if these medicines had been administered to people as prescribed because the numbers of tablets held in stock was in excess of the number of tablets expected. The provider told us that they had spoken to staff and that all staff were aware of the importance of ensuring people received their prescribed medicines. However, the provider did not have a system in place to monitor the administration of people's medicines to assure themselves that people were consistently receiving their prescribed medicines.

The failure to ensure the proper and safe management of medicines was a continued breach of Breach of Regulation 12(1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient numbers of staff working to meet people's care needs however, there were not always enough staff working within the home to facilitate meaningful engagement with people. People told us "Sometimes the staff get stressed, it is because they are so busy." Another person told us "The staff don't always have time to take us out or do things with us because [Person] needs lots of care and they have to help them." During our inspection we observed that there were three staff on duty however, one member of staff was responsible for preparing the main meal for the people living in the home. Staff were not focussed upon initiating meaningful engagement with people.

The provider told us that staffing levels were not calculated on assessed needs but were determined by the fees that commissioners purchasing people's care and support were willing to pay. During the first day of our inspection the provider was not present within the home due to a planned holiday. The provider told us that they usually work within the home to increase staffing levels. The provider had not taken into account the impact of their absence upon staffing levels and the impact that this would have upon people's experience of living within the home.

Risks to people had been assessed and the staff providing people with care and support were knowledgeable about how to mitigate people's known risks. People told us that they felt safe, their comments included; "I'm as safe as I can be" and "I am safe. The staff look after me." People had a range of risk assessments in place that were reviewed monthly as part of their individual plans of care that provided guidance to staff on how to minimise the risks to people. Staff told us "We know people well and work to

keep them safe. If we are ever unsure then we can ask the manager or look at people's care plans."

People were protected from the risk of harm. Staff were knowledgeable about the steps to take if they were concerned people may be at risk. One member of staff told us "If anyone was at risk I would report it to the manager straight away or one of the other on-call managers or directors if I needed to." Staff had received training on how to protect people from harm and records we saw confirmed this.

Safe recruitment processes were in place to protect people from the risks associated with the appointment of new staff. We saw that references had been obtained for staff prior to them working in the service as well as checks with the Disclosure Barring Service (DBS). The registered manager told us that she operated a thorough recruitment process and would only employ staff that she felt would be competent to work in the service.

Requires Improvement

Is the service effective?

Our findings

People's ability to consent to their care and support had not consistently been considered by the provider when developing people's plans of care. For example, a number of people living at St Michaels House smoked cigarettes. Staff controlled people's access to cigarettes and ensured that people living in the home only smoked one cigarette per hour. Staff told us that they supported people to manage their cigarette consumption because without this support people would chain smoke and would not have sufficient funds to purchase cigarettes. However, we observed people asking for cigarettes and being told that they had to wait by staff. The provider told us that they had developed these plans of care because they were in people's best interests however, we could not see that any formal assessment of people's capacity had been completed to show that they lacked capacity to manage their own cigarette consumption and therefore required staff to place restrictions upon their access to cigarettes in their best interests.

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. On a day to day basis people's ability to consent to their care and support was not sought or considered by staff.

Staff had received training in The Mental Capacity Act however, did not apply this training on a day to day basis. The provider was not clear of their responsibility to assess people's capacity and ensure that any decisions made for people who may lack capacity are documented and made in their best interests.

Therefore we found that the provider was in breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the registered manager had made appropriate DoLS applications to the local authority where people had been assessed as lacking capacity to be able to consent to their care.

Staff were able to access on going training and development opportunities that were relevant to their role. One member of staff told us "We refresh our training every year; the manager is very good at making sure we all do our training." The provider told us that they had recently sourced a new training provider and that they ensured all staff attended annual face to face training sessions to refresh their knowledge in key areas such as safeguarding and health and safety. Staff also had access to regular supervision and support from the registered manager to enable them to reflect upon their practice and identify areas of development.

People were supported to maintain a healthy diet and to have enough to eat and drink. One person told us "We are asked what food we would like to go onto the menu and if there is something we don't like then the staff cook us something different. I don't like fish and chips so when they have that I have egg and chips instead."

People were supported to access health services when they needed to and referrals were made to people's allocated health professionals in a timely manner. Where health professionals had implemented plans of care these were followed by staff in the home. One person told us "If we need to see our doctor then someone will book us an appointment." A visiting healthcare professional told us "I visit every 6 to 8 weeks and the staff always let me know if I need to be aware of any changes to people's health."

Requires Improvement

Is the service caring?

Our findings

The quality of interaction and the relationships between staff and people living in the home was inconsistent. People told us "Sometimes the staff lose their temper and shout." Another person told us "The staff are alright. They are very busy though; there is usually only one or two staff and they have to do all of the cooking." We discussed this feedback with the provider who was unaware of any occasion when staff had shouted at people living in the home and told us that this conduct would not be tolerated within the home. During our inspection we did not observe any meaningful interaction between the staff and people living in the home. Staff were focussed on preparing the meals for people living in the home and did not provide any form of engagement or activity that we observed.

We brought this to the attention of the provider at the end of the first day of inspection; they spoke to the staff that had been working on shift during our inspection. These staff reported that they felt unable to engage with people as they normally would due to the presence of the inspection team within the home, However, our observations and feedback from people living in the home showed that staff are focussed upon tasks within the home and did not have consistent positive, meaningful engagement with the people living at St Michaels House. For example during our inspection we observed very limited engagement between people living in the home and staff because staff were focussed upon preparing meals in the kitchen.

We also observed staff providing one person who had limited verbal communication with their meal in their bedroom. The member of staff did not greet this person when they entered their bedroom but moved a table to their bed, placed their meal down and left the room. We reported this observation to the provider who discussed this with the member of staff who provided a statement contradicting our observations during our inspection.

People were not always referred to respectfully by staff. For example, we observed a member of staff call across the dining area of the home to ask one person to take their medication. The member of staff shouted "[Name] Come" and walked into the kitchen to wait for the person to follow them.

The provider told us that they sought feedback from people living in the home through monthly "residents meetings"; however we could not see any evidence that these meetings had been taking place consistently. People also told us that they felt unable to raise any concerns during these meetings because they were concerned providing feedback would result in unfavourable treatment from staff. One person told us "I am scared to say anything in meetings in case they make me leave."

Staff knew people well and provided care in line with people's preferences. For example, one person had a cup that they preferred their drinks to be made in. We observed that staff ensured they made this persons hot drinks and gave them their drinks in their favourite cup. Staff also told us that they tried to bring in magazines for one person because they enjoyed reading through magazines together. On the day of our inspection the planned meal was fish and chips. Staff told us that "[Person] doesn't like fish so we always do them eggs instead."

Staff ensured that people's privacy was maintained when they were supporting people with their personal care. For example, we observed staff closing people's bedroom doors when supporting them with personal care. We also found that staff ensured that people's personal records such as care plans were stored securely and were not accessible.

Inadequate

Is the service responsive?

Our findings

People had plans of care in place to give direction for staff in providing care and support to people living in the home. These plans of care were focussed upon the care needs of people living in the home and provided little information for staff in relation to people's preferences, interests or life histories. People received the care that they needed on a day to day basis to meet their care needs and to maintain their safety. However, people's plans of care and the support that they received did not enable people to maintain or develop new skills to increase their level of independence.

A number of people we spoke to as part of this inspection told us that they had aspirations to live more independently however, the support that they received whilst living at St Micheals House did not enable them to do this. For example, one person told us "I want a place of my own. I told staff but they don't do anything about it." Another person told us "I am not allowed to do my own cooking. I like a fry up but I am not allowed to cook one." Another person told us "I would like to cook but I am not allowed. I would need help because I forget to turn the gas off."

People who no longer wished to live in the home had not been supported to contact the people responsible for commissioning their care to request a review of their accommodation and care needs. One person told us "I have told the manager that I would like to move out and she told me that it is down to me to sort. I know I need to join the housing list but I'm not sure how." Another person told us "I wish I could live somewhere else. I am not happy here. It depresses me."

We discussed this feedback with the provider who told us that they did not believe that people would be able to live in a more independent environment because they would not be safe. The provider also told us that people had not had a review of their care needs by their funding authorities and we could not see that a review had been requested when people had stated that they no longer wished to live in the home. People were not involved in developing their plans of care and were not supported to develop plans to enable them to achieve their individual aspirations. People were not encouraged to complete tasks to develop the skills that they would need to live independently and their personal aspirations were not considered by staff when providing their care.

Staff told us that they did offer people activities however, people chose not to participate in these. One member of staff told us "We do art sessions with people and offer baking to one person each week. I also bring in the Argos catalogue and look through this with [Person]." However, the people we spoke to told us "There's not a lot going on. It does get boring" and "I can't always do my baking because the staff are busy." People's plans of care were reviewed by staff each month however, no changes were made to the care and support people received. The reviews conducted by staff within the home had identified that people had not engaged in activities however, no new strategies had been developed or deployed by staff to encourage people to participate in leisure and social activities and to lead fulfilled lives to aid their sense of wellbeing. During our inspection we observed that people spent their time watching television in the communal lounge or dining room or smoking in the garden. We did not observe any activities facilitated by staff to enhance people's sense of well-being.

This constituted a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person Centred Care.

People were encouraged and supported to maintain relationships that were important to them. For example, staff supported one person to visit their family each week and supported them to budget their income so that they were able to have money to spend when they were with their family. Staff had worked closely with other professionals involved in this person's care to develop guidelines to maintain their safety whilst visiting their relatives.

The provider had a complaints policy in place however, had not received any formal complaints since our last inspection. We reviewed the records maintained relating to complaints and saw that no formal complaints about the home had been received. The registered manager had recently sent out satisfaction surveys to people using the service and was in the process of analysing these results.

Inadequate

Is the service well-led?

Our findings

During our last inspection in May 2016 we found that the provider was in breach Regulation 17 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. That was because the inspection highlighted shortfalls in the service that had not been identified by monitoring systems used by the provider. The provider had not deployed appropriate systems or processes to assess, monitor and improve the quality and safety the care that people received. We rated this domain as requires improvement and asked the provider to send us an action plan to tell us how they planned to improve the leadership of the service; however, they did not submit an action plan to us. The provider displayed their previous inspection rating within the home for people and visitors to see in the dining area.

During this inspection we found that the provider remained in breach of Regulation 17 (1) (a) of the Health and Social Care Act 2008. The provider had failed to implement effective systems to monitor, assess and improve the quality of care provided to people.

This inspection identified continued shortfalls in relation to the management of people's medicines, this had also been identified by local commissioners. However the provider failed to implement an effective system of quality assurance to improve the quality and safety of the management of medicines. People were at continued risk of not receiving their prescribed medicines because the provider had no system of quality assurance to monitor how people received their medicines.

The provider had failed to implement a system of audits to consider the cleanliness and maintenance of the home. During this inspection we identified a number of areas that were in need of renovation that the provider had failed to identify, or to develop strategies to resolve.

The provider told us that they were aware that a number of areas within the home were in need of redecoration and maintenance however, they had not developed a systematic approach to resolve this. We found that areas of the home smelt damp and had mould on the walls and window sills. We identified that the side of one of the baths was no longer fully attached to the bath; the dining table was in danger of collapsing because it had a broken leg. We also found that carpets and flooring throughout the home were stained and damaged. The provider told us that they had not identified funds for works to the building or developed their business plan for the financial year. This meant the provider could not provide any assurances that the home would be maintained adequately.

This inspection has highlighted two continuing breaches of the Health and Social care Act 2008 that the provider had failed to address. This has resulted in people being exposed to the continuing risk of harm through omissions in their care because the provider has failed to implement effective governance systems.

People living in the home did not have the confidence that they needed to approach the provider to provide honest feedback. The provider was visible in the home and sought feedback from people however; people reported that they felt unable to raise concerns with the provider or staff because they were fearful of the potential consequences of doing so. We did not find any examples whereby people had been subject to

negative experiences for providing feedback to the provider or staff however, the systems adopted by the provider to gather feedback were not effective at enabling people to do this openly. People were supported by staff to complete annual questionnaires to provide feedback about the care and support that they received however, this system was not effective at gathering honest feedback from people and had not identified the issues that we found during this inspection. The provider was aware that a number of people living in the home had aspirations to explore other accommodation options however, had not acted upon this feedback because they did not believe that people's aspirations were realistic. They had not supported people to explore what skills they may need to live independently or acted upon their feedback and contacted the people responsible for commissioning their care to report their wish to live more independently.

The failure to provide appropriate systems or processes to assess, monitor, act upon feedback from people and improve the quality and safety of services was a breach of Regulation 17 (1) (a) (e) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a culture in the home whereby people were not valued. The registered manager and staff were focussed upon the areas where people required support and actions to maintain their safety. Staff told us that the aims of the service "Were to keep people safe". At times this had resulted in people experiencing restrictions. There was no focus on enabling people to develop independence or involving people in the planning of their care and support. The provider who was also the registered manager had not been proactive in referring people to appropriate agencies when they expressed a desire to leave the home and a number of people that we spoke to expressed a wish to explore different accommodation options. Staff told us that there was a stable staff team that knew people well.

The service was being managed by a registered manager who was aware of their legal responsibilities to notify CQC about certain important events that occurred at the service. The registered manager had submitted the appropriate statutory notifications to CQC such as DoLS authorisations, accidents and incidents and other events that affected the running of the service.

This section is primarily information for the provider

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 9 HSCA RA Regulations 2014 Person-centred care Plans of care were focussed upon the care needs of people living in the home and provided little information for staff in relation to people's preferences, interests or life histories. Plans of care and the support that people received did not enable people to maintain or develop new skills to increase their level of independence. This constituted a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person Centred Care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Restrictions had been placed upon people as part of their plans of care however, people's capacity to consent to their care and support had not been assessed. Therefore we found that the provider was in breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People could not be assured that they would receive their prescribed medicines safely. The failure to ensure the proper and safe management of medicines was a continued

	breach of Breach of Regulation 12(1)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17 (1) (a) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.