St Michael's Care Homes Limited

St Michaels Nursing 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected St Michaels Nursing Home on the 11 October 2016. We previously carried out a comprehensive inspection at St Michaels Nursing Home on 11 and 12 June 2015. We found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in respect to cleanliness and infection control, people not being treated with dignity and respect, inconsistent care planning and delivery, people's consent to care and treatment, staffing levels and quality monitoring. The service received an overall rating of 'requires improvement' from the comprehensive inspection on 11 and 12 June 2015. After this inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and to check that the provider had followed their action plan, and confirm that the service now met legal requirements. We found improvements had been made in the many of the required areas. Improvements had been made in respect to cleanliness and infection control, people being treated with dignity and respect, inconsistent care planning and delivery and people's consent to care and treatment. However, we continue to have concerns in respect to staffing levels. Further areas of improvement were also identified in relation to person centred care, quality monitoring and meeting people's social and recreational needs.

St Michaels Nursing Home is registered to provide accommodation and care, including nursing care for up to 39 older people, with a range of medical and age related conditions, including arthritis, frailty, mobility issues and dementia. On the day of our inspection there were 26 people living in the service, who required varying levels of support.

There was a manager in post, who had applied to become the registered manager. However, at the time of our inspection, they were not registered with the CQC. 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.

People's safety was sometimes being compromised as people and staff commented they felt there were not enough care staff to provide safe care. Our own observations supported this. Staffing levels were stretched and staff were under pressure to deliver care in a timely fashion. One person told us, "The staff are so

rushed, they don't have enough time to do anything". Another person said, "The staff don't always answer the call bell and I have sometimes waited ages for someone to come".

Several people commented they were well looked after by care staff. However, care was not always personalised to the individual. For example, people did not always get up or go to bed when they wished. It was recognised that staff had a good understanding of person centred care and knew people's routines well. However staffing levels at the service did not allow staff to routinely meet people's preferences in relation to how their care was delivered.

There were some arrangements in place to meet people's social and recreational needs and in response to the previous inspection, the service now employed a dedicated activities co-ordinator. However, we could not see that activities were routinely organised for everybody or for people at the weekend or in the evening, and staff struggled to make time to engage socially with people due to staffing levels.

The manager had introduced a range of quality assurance audits to help ensure a good level of quality of care was maintained. We were given several examples of improvements made since the previous inspection, such as improvements to the environment and infection control, the mealtime experience, the analysis of accidents and incident, and improvements to care practice in light of people's feedback. However, these audits had not fully ensured that people received a consistent and good quality service that met individual need. The provider had also not met all of the required improvements set out in their action plan created in light of the concerns identified at the previous inspection.

People felt well looked after and supported. We observed friendly and genuine relationships had developed between people and staff. One person told us, "The staff are lovely, always smiling and friendly even when they are rushed off their feet". Another person said, "The staff are lovely, kind and considerate". Care plans described people's needs and preferences and they were encouraged to be as independent as possible.

People were being supported to make decisions in their best interests. The manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future. Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

Staff had received essential training and there were opportunities for additional training specific to the needs of people, including caring for people with pressure damage and palliative (end of life care). Staff had received both one-to-one and group supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place. One member of staff told us, "It is vitally important that the training is good, as we need the right skills to help people, and it is".

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. One person told us, "The food is very good and there's plenty of it. The staff will help you with cutting it up if you need to". Special dietary requirements were met, and people's weights were monitored with their permission. Health care was accessible for people and appointments were made for regular check-ups as needed.

People were encouraged to express their views and feedback received showed people felt staff were friendly and helpful. People said they felt listened to and any concerns or issues they raised were addressed. People were also encouraged to stay in touch with their families and receive visitors.

Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns.

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 consistently safe.

Staffing levels were incorrectly calculated and did not reflect people's level of care needs and support required to safely meet their needs.

The provider used safe recruitment practices and staff understood their responsibilities in relation to protecting people from harm and abuse.

Potential risks were identified, appropriately assessed and planned for. Medicines were managed and administered safely.

Is the service effective?

Good

The service was effective.

People spoke highly of staff members and were supported by staff who received appropriate training and supervision.

People were supported to have sufficient to eat and drink. Their health was monitored and staff responded when health needs changed.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity were respected and their independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always consistently responsive.

People did not always receive the care they required at the time they needed it. The delivery of care often suited staff routine, rather than people's individual preferences and choices.

There were some arrangements in place to meet people's social and recreational needs. However, activities were not routinely organised for people at the weekend or in the evening.

Comments and compliments were monitored and complaints acted upon in a timely manner. Care plans were in place and were personalised to reflect peoples' needs, wishes and aspirations.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance processes identified aspects of the service that required improvement, however the service had not ensured action had been taken to fully rectify the issues identified at the previous inspection.

People, relatives and staff spoke highly of the manager. The provider promoted an inclusive and open culture and recognised the importance of effective communication.

Forums were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement.

St Michaels Nursing 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 checked 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.

We inspected St Michaels Nursing Home on the 11 October 2016. We previously carried out a comprehensive inspection at St Michaels Nursing Home on 11 and 12 June 2015. We found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in respect to cleanliness and infection control, people being treated with dignity and respect, inconsistent care planning and delivery, people's consent to care and treatment, staffing levels and quality monitoring. The service received and overall rating of 'requires improvement' from the comprehensive inspection on 11 and 12 June 2015. After this inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

Two inspectors and an expert by experience in older people's care undertook 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. Before our inspection we reviewed the information we held about the service. We considered information which had been shared with us by the local authority and clinical commissioning group, and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We observed care in the communal areas of the service. We spoke with people and staff, and saw how people were supported during their lunch. We spent time observing care and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including five people's care records,

four staff files and other records relating to the management of the service, such as training records, food and fluid recording charts, accident/incident recording and audit documentation.

During our inspection, we spoke with seven people living at the service, three visiting relatives, five care staff, the manager, a member of ancillary staff, a registered nurse and the cook. We also 'pathway tracked' the care for some people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires Improvement

Our findings

At the last inspection on 11 and 12 June 2015, the provider was in breach of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in respect to cleanliness and infection control and staffing levels. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made in relation to cleanliness and infection control and the provider was now meeting the legal requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we identified ongoing concerns in relation to staffing levels at the service that placed people at risk. We found the provider was still in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff at St Michaels Nursing Home told us there were not enough care staff on duty to support people at the times they wanted or needed. For example, one person told us, "The staff are so rushed, they don't have enough time to do anything". Another person said, "The staff don't always answer the call bell and I have sometimes waited ages for someone to come". Throughout the inspection we heard call bells ringing repeatedly. One person told us, "You can ring the bell and wait ages for someone to come". Another person said, "I rang the bell in the night and they came and said they'd come back, but never did, so now I don't bother".

Feedback from staff was mixed, some told us that they felt rushed and under pressure in relation to their work. One member of staff told us, "I don't think there are enough staff, it's really busy. It's really hard and we are literally running everywhere, it's very hectic". They added, "The staffing is the only issue in this home. If we just had one or two more staff to float, that would really take the pressure off". Another member of staff said, "Nine times out of ten we have enough staff. Some days are heavier than others. For the staff we've got, we do well". A further member of staff added, "Some days it is not enough [staff], it's very busy there is a lot of work to do, but other days it's ok".

Our own observations supported the feedback we had received. During our inspection we viewed care delivery at different times throughout the service. Staff often rushed between tasks and appeared busy and preoccupied. Several people had requests unanswered. For example, we spoke with one person in their room. They told us they had been awake since 5:00am and had not received their breakfast until 10:00am, and was still waiting at 11:00am for personal care to get them out of bed. Additionally, we spoke with another person, who was in their night clothes in bed. They told us that their bed clothes were soiled and that they had been waiting a long time to receive personal care, despite making staff aware that they were

wet and in need of attention. Furthermore, at 3:00pm in the lounge we observed one person state to a member of staff that they wished to be taken to their room in order to go to bed. The member of staff was busy and replied, "We've spoken about this [person], you need to wait. We have to do the others first who need us more than you". The person became agitated and started to move from side to side in their chair. They asked again to be taken their room, however the member of staff replied, "[Person] don't move. I say this every day to you don't I, you have to wait".

We observed that care staff were present most of the time in communal areas such as the lounge and dining room. However, we did observe times when there was not a staff presence in the lounge. At 10:25am we observed that seven people with limited mobility had been brought through to the lounge from the dining area after breakfast. At 10:40am one person asked another, "Can you hear the TV?" "No I can't" they replied. A third person said, "Neither can I, it's so frustrating. We'll have to ask if somebody comes in". There were no members of staff present until 10:45am, when one person asked a member of the inspection team to get a member of care staff to turn up the TV.

The manager told us that staffing levels were calculated based on each person's level of dependency (care needs), which determined the required staffing numbers. They told us the information was based on individual care plans and the assessed level of need documented and that audits of staffing levels had taken place. However, our own observations showed that staffing levels were not assessed correctly. The current assessment for staffing levels was not accurate and there were not sufficient staff to ensure people's needs could be met safely.

The above evidence demonstrated that there were not always sufficient numbers of care staff to safely support people's care needs. We found the staffing levels to require improvement and placed people at risk. This was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the physical environment of St Michaels Nursing Home required improvement. At this inspection the service was clean and free from offensive odours, and furniture and floors appeared clean. The manager told us that the works to improve the environment had been completed following the previous inspection. New flooring had been laid and extra cleaning staff had been employed. Additionally, the service had designated a member of staff as an infection control lead. Cleaning schedules had been implemented and followed, and regular audits had ensured that improvements had been maintained.

Accidents and incidents were reported, monitored and patterns were analysed, so appropriate measures could be put in place if required. There were also a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place.

There were systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs. The assessments outlined the activity, the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff transferring people from their wheelchair to an armchair and assisting them to mobilise around the service.

Risks associated with the safety of the environment and equipment were identified and managed

appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of electrics, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

Staff had been recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The service had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form. Files contained evidence to show where necessary that staff belonged to the relevant professional body. Documentation confirmed that all nurses employed had registration with the nursing midwifery council (NMC) which were up to date.

We looked at the management of medicines. The registered nurses were trained in the administration of medicines. A registered nurse described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks and cleaning of the medicines fridge. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed.

We saw a nurse administering medicines sensitively and appropriately. Nobody we spoke with expressed any concerns around their medicines. Medicines were stored correctly and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of appropriately.

Good

Our findings

At the last inspection on 11 and 12 June 2015, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in respect to the recording and assessment of consent and the understanding of staff in relation to consideration of depriving somebody of their liberty. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the need for consent. Improvements had been made and the provider was now meeting the legal requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. 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).

We checked whether the service was working within the principles of the MCA. Following the previous inspection, the manager had implemented capacity assessments for all people that required them, which were stored in people's care plans. Furthermore, training had been made available for staff in relation to the MCA and DoLS. Staff we spoke with told us that they had received training and shared their knowledge of the principles of the MCA. They gave us examples of how they would follow appropriate procedures in practice. Staff told us they explained the person's care to them and gained consent before carrying out care. Throughout the inspection, we saw staff speaking clearly and gently and waiting for responses. Staff members recognised that people had the right to refuse consent. The manager and staff understood the principles of DoLS and how to keep people safe from being restricted unlawfully. The manager added, "All staff have now done MCA and DoLS training and assessments are in place for people". They also knew how to make an application to deprive a person of their liberty, and we saw appropriate paperwork that supported this.

People told us they received effective care and their individual needs were met. One person told us, "The staff are well trained". People we spoke with said that they had confidence in the ability of the staff that provided care. They stated that staff knew what they were doing. A member of staff added, "It is vitally important that the training is good, as we need the right skills to help people, and it is".

Staff told us the training they received was thorough and they felt they had the skills they needed to carry out their roles effectively. Training schedules confirmed staff received essential training such as, moving and handling, dignity and respect and infection control. Staff had received training that was specific to the needs of the people living at the service, this included caring for people with pressure damage and palliative (end of life care). Staff spoke highly of the opportunities for training. One member of staff told us, "The training is very good. I'm doing my NVQ (National Vocational Training". Another member of staff said, "I've just had training around dementia and the MCA".

The provider operated an effective induction programme which allowed new members of staff to be introduced to the running of St Michaels Nursing Home and the people living at the service. Staff told us they had received a good induction which equipped them to work with people. One member of staff told us, "The induction was really useful. I'd never worked in care before and it gave me good advice". Another member off staff said, "I learned so much on my induction, I have learned so much here". The manager added, "The induction involves shadowing more experienced staff and training. All new staff are put on an NVQ (National Vocational Qualification). The induction can be extended if they are not confident and I sign off when they are ready". There was an on-going programme of supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff members commented they found the supervision useful and felt able to approach the manager with any concerns or queries. One member of staff told us, "I get regular supervisions".

Care records demonstrated that when required, referrals had been made to appropriate health professionals. People commented that their healthcare needs were effectively managed and met. Staff confirmed they would recognise if somebody's health had deteriorated and would raise any concerns with the appropriate professionals. They were knowledgeable about people's health care needs and were able to describe signs which could indicate a change in their well-being. One member of staff told us, "I know what to do if we see people deteriorate. We always keep a close eye on everyone in case there are any changes and we go straight to a nurse". We saw that if people needed to visit a health professional, such as a GP or an optician, or go to hospital, then a member of staff would support them.

People were complimentary about the food and drink. One person told us, "The food is very good and there's plenty of it. The staff will help you with cutting it up if you need to". Another person said, "Plenty of fresh vegetables and fruit. The kind of food I like". A further person told us how they could make specific requests to the cook. They told us they did not like English food, therefore the service ensured that they provided them with food from their home country. People were involved in making their own decisions about the food they ate. Special diets were catered for, such as fortified and vegetarian. For breakfast, lunch and supper, people were provided with options of what they would like to eat. The cook confirmed that if relatives wanted to eat with their family member, a meal would be prepared for them. The menu showed that fresh vegetables were used daily, as well as fresh fish and meats.

We observed lunch in the dining room and lounge. It was relaxed and people were considerately supported to move to the dining area, or could choose to eat in their room or the lounge. Tables were set with napkins, the cutlery and crockery were of a good standard, and condiments were available. The food was presented in an appetising manner and people spoke highly of the lunchtime meal. The atmosphere was calming and relaxing for people. People were encouraged to be independent throughout the meal and staff were available if people wanted support, extra food or additional choices. Staff understood the importance of monitoring people's food and drink intake and monitored for any signs of dehydration or weight loss. Where people had been identified at risk of weight loss, food and fluid charts were in place which enabled staff to monitor people's nutritional intake. People's weights were recorded monthly, with permission by the individual. Where people had lost weight, we saw that advice was sought from the GP.

Good

Our findings

At the last inspection on 11 and 12 June 2015, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns that the provider had not ensured that staff must offer choice and treat people with dignity and respect, and all communication with them must be respectful. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to treating people with dignity and respect. Improvements had been made and the provider was now meeting the legal requirements of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we found the principles of privacy and dignity were not embedded into every day care practice. We saw at this inspection, that people were supported with kindness and compassion. The manager told us that the importance of treating people with dignity and respect was reiterated at team meetings and formed part of the training delivered to new staff at induction. The manager carried out spot checks and 'walked the floor' regularly to ensure that the care delivered was dignified and staff treated people appropriately. People told us that caring relationships had developed with the staff who supported them. One person told us, "The staff are lovely, always smiling and friendly even when they are rushed off their feet". Another person said, "The staff are lovely, kind and considerate". A member of staff told us, "We all really care for the residents".

Staff showed kindness when speaking with people. They always approached people face on and at eye level, they demonstrated empathy and compassion for the people they supported. One person told us, "They [the staff] are very friendly and helpful". A member of staff added, "We really get to know the residents and have a laugh with them".

Throughout the inspection, people were observed moving around the service and spending time in the lounge or dining area. People's rooms were personalised with their belongings and memorabilia. People showed us their photographs and other items that were important to them. People were supported to maintain their personal and physical appearance. They were dressed in the clothes they preferred and in the way they wanted.

Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One person told us, "I praise the staff for their attention to detail and kindness when I am being attended to". A member of staff said, "We offer choices to people. For example, where they would like to eat and if they would like to stay up late". Another member of staff said, "Everyone gets a choice as to

what they do". The manager added, "We document people's choices in their care plans. For example, we don't want to get people up out of bed if they don't want to be got up. We try to let people do what they want".

We looked at the arrangements in place to protect and uphold people's confidentiality, privacy and dignity. Staff members had a firm understanding of the principles of privacy and dignity. As part of staff's induction this was covered and the manager undertook checks to ensure staff were adhering to the principles of privacy and dignity. They were able to describe how they worked in a way that protected this. One member of staff told us, "We use the correct equipment and we make sure we cover people during personal care. Our comments need to be appropriate and encouraging, and we respect their dignity". People confirmed staff upheld their privacy and dignity, and we saw doors were closed when a member of staff was engaged with a person. Care records were stored securely. Confidential Information was kept secure and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training pertaining to this.

Staff supported people and encouraged them, where they were able, to be as independent as possible. The manager told us, "Staff encourage people to do things for themselves". Staff informed us that they always encouraged people to carry out personal care tasks for themselves, such as brushing their teeth and hair. A member of staff told us, "We encourage residents to help themselves, to keep their skills going". People were able to maintain relationships with those who mattered to them. Visiting was not restricted and guests were welcome at any time. People could see their visitors in the communal areas or in their own room.

Requires Improvement

Our findings

At the last inspection on 11 and 12 June 2015, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns that the provider had not ensured that people were involved in the planning of their care, that they had the opportunity to take part in meaningful activities and that they received person centred care that reflected their preferences. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made and the provider was now meeting the legal requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People commented they were well looked after by care staff and that staff listened to them, and responded to their needs and personal preferences. However, our own observations and feedback we received in relation to activities identified areas of practice which were not consistently responsive to people's individual needs and need improvement.

Several people commented they were well looked after by care staff. However, care was not always personalised to the individual. For example, people did not always get up or go to bed when they wished. One person told us how they had woken up at 5:00am and wished to get up, but this did not happen until past 11:00am. We observed another person being told several times that they needed to wait before they could be taken to their room in order to have a lie down. We asked staff if people's choices and preferences were respected around getting up and going to bed. A member of staff told us, "We didn't get one person up today until 11:30am. We should really have everybody ready by about 10:30am. Everyone has their own routine, but it's just such a rush because of the staffing levels. We have so many people to get up, that sometimes there's not really a choice for people". Another said, "We get to know people and try to respect what they want, but it's such a busy home. We do try our best". It is recognised that staff had a good understanding of person centred care and knew peoples routines well. However, staffing levels at the service did not allow staff to routinely meet people preferences in relation to how their care was delivered. We have identified this as an area of practice that needs improvement.

In response to the previous inspection, the service now employed a dedicated activities co-ordinator, and we saw there were some arrangements in place to meet people's social and recreational needs and. However, we could not see that activities were routinely organised for everybody or for people at the weekend or in the evening, and staff struggled to make time to engage socially with people due to staffing levels. Feedback from staff and our own observations clearly indicated this need was not being fully addressed.

On the day of the inspection, we saw an activity taking place in the afternoon. We observed a visiting entertainer organise a chair based group activity session. The activity was popular and people who took part clearly enjoyed themselves. However, between 10:00am and 2:30pm, we observed that no formal activities took place for people in the lounge or in people's rooms. People spent this time sitting in their bedrooms or armchairs in the lounge or dining room watching television or listening to music. Apart from the delivery of individual care, there was little meaningful interaction with people in terms of stimulation and engagement. A member of staff told us, "There are no activities really. People just watch TV. Some people don't actually want to do anything, but I don't think their needs are being met. We'd love to spend more time with them, but everything depends on staff and we don't have enough". Another member of staff said, "I think it could be better here in terms of activities. It's not very positive and they need more variety, but we're restricted with the amount of time we have to interact with them". A relative added, "The activities are no more than a lip service to an idea". Another relative said, "The staff don't do anything with them, they are just sat in the lounge and left to watch TV". However, we observed that when staff did take the time to engage with people, that they responded positively and clearly enjoyed the opportunity to reminisce and discuss various topics.

We saw there was an activities diary and activities file, as well as individual 'working & playing' plans in people's care plans. The diary was kept by the activities co-ordinator and showed that one to one sessions with people for chats and nail care had taken place. The diary also recorded who attended the hairdresser and who had watched TV and a DVD in lounge. It also listed external entertainers and who attended. However, a month's worth of activity records showed no engagement with some people and we could not see planning to ensure everybody got a share of activities on offer. The activities file appeared newly implemented and had a section for each person. Life histories were detailed here and were of a good quality, however the provision of activities did not yet include all the people living at the service and only took place during standard working hours. We raised this with the manager who stated they were aware of the lack of meaningful activities for people outside of standard working hours, and stated that staffing levels dictated this.

Providing people with meaningful interaction and stimulating activities is an important part of improving their quality of life. Having companionship and someone to talk to assists with maintaining people's mental and physical wellbeing, and is an integral part of providing person centred care. We have identified this as an area of practice that needs improvement.

In response to the previous inspection, people or their relatives were involved in the formation of the care plans and were subsequently asked if they would like to be involved in any care plan reviews. The manager told us, "I have done my best with the care plans and every resident has had a care review". We saw that people's needs had been assessed and plans of care were developed to meet those needs. Care plans contained personal information, which recorded details about people and their lives. Life histories had been completed with assistance of relatives and gave a picture of each person's life and preferences. Each section of the care plan was relevant to the person and their needs. Areas covered included mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans contained detailed information on the person's likes, dislikes and daily routines with clear guidance for staff on how best to support that individual. The manager told us that staff read people's care plans in order to know more about them. We spoke with staff who confirmed this was the case and gave us examples of people's individual personalities and character traits. One member of staff told us, "I read the care plans, they are useful". Another member of staff said, "We have good banter with the residents and we have a laugh. I took my time getting to know people and learning about their history and who they are. The care plans are good, but that's just the reason they are here. We need to get to know them as people and we have".

People told us they were listened to and the service responded to their needs and concerns. There were systems and processes in place to consult with people, relatives, staff and healthcare professionals. The procedure for raising and investigating complaints was available for people to read. The complaints procedure and policy were accessible and displayed around the service. People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed by the manager. Staff told us they would support people to complain. Complaints made were recorded and addressed in detail, in line with the policy.

Requires Improvement

Our findings

At the last inspection on 29 May 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns that the provider had not ensured that effective systems and processes were in place to assess, monitor and improve the quality and safety of the service. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to premises and equipment. Improvements had been made and the provider was now meeting the legal requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we have identified an area of practice that needs further improvement.

The manager had introduced a range of quality assurance audits to help ensure a good level of quality was maintained. They showed us audit activity which included health and safety, medication, care planning and infection control. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans accordingly to improve the quality of the care delivered. We were given several examples of improvements made since the previous inspection, such as improvements to the environment and infection control, the mealtime experience, the analysis of accidents and incidents, and improvements to care practice in light of people's feedback.

However, these audits had not fully ensured that people received a consistent and good quality service that met individual need. For example, staffing levels were not correctly assessed and the provision of person centred care and meaningful activities were not yet robust or fully embedded. The manager told us, "I feel that to complete the improvements that we have made, that an extra member of staff should be employed to cover the busiest hours of the day". Additionally, the provider had not met all of the required improvements set out in their action plan created in light of the concerns identified at the previous inspection. For example, the action plan received in September 2015 stated that staffing numbers had been increased in November 2014 in order to meet people's assessed needs. However, at the previous inspection on 11 and 12 June 2015 staffing levels were not adequate and no increase in numbers or improvement has been made subsequently by the provider. This placed people at risk of receiving negative outcomes and care that did not meet their needs, and is an area of practice that needs improvement.

People and staff told us that improvements had been made since the previous inspection and were satisfied with the way the service was managed. One person told us, "The manager and staff are really trying to make things better". A relative said, "There have been improvements. When I first came here the lounge stank of urine, but they've taken up the carpet and put a new floor down which is better". Another relative added,

"Things are much better than they were six months ago". A member of staff added, "The manager is getting on top of everything and it is improving all the time". A further member of staff told us, "Since [manager] has come to the home, there's been a lot of improvement. She's the best manager we've ever had". The manager added, "I walk the floors and work out how best to run the home. Staff morale has improved. There have been a lot of managers, but now there is stable management in place".

Staff commented they felt supported and were happy working at St Michaels Nursing Home. One member of staff told us, "I'm happy working here". Another member of staff said, "I absolutely love working here, I would never leave". A further member of staff added, "I'm supported. I only have positives to say about working here, no negatives. Having a good manager makes all the difference". We discussed the culture and ethos of the service with the manager and staff. They told us, "The home is good. We're listened to and the care is good. Everything is there for us and the residents". Another member of staff added, "We all help each other and we like the residents very much. I see on the faces of the residents that they are smiling. The care is good and the residents are happy and well cared for". The manager added, "I have some very loyal carers, staff and nurses with lots of commitment".

Staff said they felt well supported within their roles and described an 'open door' management approach. One member of staff said, "We can approach [manager] at any time, she gets things done". Another member of staff said, "We really care. If there is a problem, the manager's door is always open". A further member of staff added, "I love working here. We all work together as a team and we have good nurses. Everybody loves the manager and we work together like a family".

People and staff were encouraged to ask questions, make suggestions and report any problems or concerns. We were given an example where feedback from people had led to lighter chairs being provided to make it easier for visitors to move them. We were given another example where feedback from staff had led to changes in the way that care equipment was stored in people's rooms. These changes had improved the efficiency of staff providing care. The manager told us, "I always encourage anybody to raise issues and ideas". A member of staff said, "The manager listens to us and we listen to the residents". Staff were aware of the whistle blowing policy and when to take concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively. We saw that policies, procedures and contact details were available for staff to do this.

The service has been without a registered manager since July 2014. The current manager had been in post for approximately eight months. Management was visible within the service and the current manager took an active approach. The manager told us, "I am hands on and approachable, I want to listen and support the staff". The service had a strong emphasis on team work and communication sharing. There were open and transparent methods of communication within the home. Staff attended daily handovers. This kept them informed of any developments or changes to people's needs. One member of staff told us, "Handover is really useful. We talk about the residents and how we are going to work for the day". Staff commented that they all worked together and approached concerns as a team. One member of staff said, "We all get on well and support each other".

Mechanisms were in place for the manager to keep up to date with changes in policy, legislation and best practice. Up to date sector specific information was also made available for staff, and the manager received updates from the nursing and midwifery council (NMC) and the care of people with dementia. We saw that the service also liaised with the Local Authority and Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery, and learning was cascaded down to staff.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were always sufficient numbers of staff to safely support people's care needs.

The enforcement action we took:

The current assessment for staffing levels was not accurate and there were not sufficient staff to ensure people's needs could be met safely. There were not always sufficient numbers of staff to safely support people's care needs. We found the staffing levels to require improvement and placed people at risk.