Shakthi Healthcare Limited

St. Michaels Lodge

Inspection report

St. Michaels Lodge
68 Bulwer Road
London
E11 1BX

Date of inspection visit:
24 February 2016
25 February 2016
26 February 2016

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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

The inspection took place on the 24 and 25 February 2016 and was unannounced on the first day.

The service provides accommodation and 24 hour support for up to 10 people with mental health needs. At the time of our inspection five people were using the service.

Two bedrooms on the ground floor had en suite bathrooms and the other eight bedrooms had a sink and people shared bathroom facilities.

There was a registered manager 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 service did not always keep people safe. Staff had been trained in safeguarding but were not always recruited safely. People and their relatives said they felt safe and that staff protected them in the service. There were enough staff at the service delivering care and support and they had been trained to provide support to people.

The systems to ensure staff were of good character were insufficient. We have recommended that the service consider reviewing best practice for ensuring that staff are of good character.

People were supported to receive their medicines in a safe way and received their medicine from people who had been trained. The manager audited medicines internally and recently introduced a new system to monitor medicines.

The service was not meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs). We found that staff had been trained but did not understand the principles of the MCA or DoLs. The service may be depriving someone of their liberty without the proper authorisation and the policy on DoLs did not provide information in line with the code of practice. There was also no policy on the MCA so staff had no guidance to support them in their responsibilities for DoLs.

Staff were observed being kind to people at the service and people said that they liked the staff and spoke positively about living at the service.

Care plans and risk assessments were in place and had been updated. However care was not always person centred and staff were not aware that they had become regimented to people's routines. We observed that people were not always supported to leave the service of their own choice.

People were involved in their care at the service and the manager and staff encouraged people to feel part

of the service by helping with tasks and keeping them informed of health appointments that they were due to attend.

The manager checked the quality of the service by asking people how they felt but they did not ask staff or relatives for feedback. The manager did however carry out regular meetings with staff and discussed how the service performed.

Relatives spoke well of the manager and commented on how efficient they were and that they could easily contact them if they needed to discuss the relatives care.

We found two breaches of the regulations. You can see what action we told the provider to take at the back of the full version of this 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 not always safe.
The measures in place to ensure staff remained suitable to work in a care setting were insufficient.

People told us they felt safe and their relatives said they thought the service was safe.

Staff knew how to identify and recognise abuse and how to report it.

The service employed sufficient numbers of staff to keep people safe and there were enough staff to tend to people's needs.

Medicines were kept secure and they were administered safely by staff who had been trained.

Is the service effective?

Requires Improvement

The service was not always effective.

The service may have been depriving someone of their liberty without the proper authorisation and had not followed the code of practice to apply for a DoLs authorisation when needed. Staff showed a lack of understanding in how to apply the MCA and DoLs in their work.

Staff were given a thorough induction before commencing work and received mandatory training.

People were supported to eat and drink enough to meet their nutrition and hydration needs. People were provided with food to meet their dietary and religious beliefs. Those at risk of malnutrition were monitored more closely.

Is the service caring?

Good

The service was caring.

People were treated with dignity and compassion. We observed caring interactions between staff and people.

People's privacy was respected and people were supported to be more independent so they felt self-fulfilment in their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's choice was not always being listened to and staff were seen to be focused on people's routine and did not want to deviate from this.

People's care plans were not always responsive to their needs or person centred and did not reflect the current position or how staff should respond to requests from people.

Complaints were documented and responded to but there was no format available for people using the service.

People were taking part in activities and were seen helping around the service to avoid them feeling isolated.

The service ensured people were seen by relevant health professionals and that they were provided with this information to keep them informed.

Is the service well-led?

Requires Improvement

The service was not always well led.

People, their relatives and staff spoke positively about the manager of the service.

Feedback was sought from people but not from relatives and staff. The service was not seeking feedback which could provide information on how to improve the service.

Audits were carried out on medication and further medicines audits had been introduced after a quality audit by the local authority which showed the service acted to improve.

St. Michaels Lodge

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 24, 25 and 26 February 2016 and was unannounced.

The inspection team included one inspector and a specialist advisor with specialist training in the Mental Capacity Act and Deprivation of Liberty Safeguards and a pharmacy inspector who attended on the 26 February 2016.

The provider was not asked to complete a provider information return (PIR). We reviewed the information we held about the service and looked at notifications received. We also spoke to the local borough contracts and commissioning team and the fire service.

We spoke to five people using the service, interviewed six members of staff, the registered manager and two relatives. We observed care and reviewed the records of five people and six staff files. Policies and procedures were also reviewed during the inspection.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. The recruitment policy did not detail the number of references to be provided by staff. The manager told us they required two references but in one file only one had been returned. There was no explanation as to why the second one had not been received. The manager advised they would follow it up. Some staff had also transferred over from the previous service under employment law. However upon starting employment under new management we found a criminal records check (DBS) had not been done. We looked at six staff files and in one instance it had been over 10 years since the last DBS check. This posed a risk as the service could not be assured that people were being cared for by staff of good character. This is because the service did not perform checks to ensure that staff remained of good character. The registered manager advised they would now request an up to date DBS check. We did see that new staff had completed an application form and provided a DBS check.

We recommend that the service consult current guidance on how to check staff are of good character.

Risk assessments identified some risks and how to minimise them but positive risks were not always supported as it was outside of people's normal routine. For example where people wanted to leave the house at anytime it was not documented how staff should enable and support people.

We did see that after a fire had happened in the service people were told they now had to smoke outside during a residents meeting which we saw but care plans where people smoked were not updated to reflect the requirement to smoke outside at all times.

People told us they felt safe at the service. Relatives told us "She's 100% safe there" and "think he's ok as on first floor."

The service used CCTV to monitor who was arriving at the service and to check when people came back from going out. We also observed people wearing named badges with their picture on as another safeguard to keep people safe when they went into the community so if they became lost they could be returned back to the service.

The training matrix confirmed that staff had been trained in safeguarding adults from abuse and staff told us the different types of abuse that needed reporting. Staff told us that there was no excuse for treating people in the service badly and if they witnessed it they would inform the manager or report to the police, CQC and the local authority. Staff said they would whistle blow if they felt the service was not responding appropriately to an allegation of abuse.

We saw records to confirm staff received training on how to respond to behaviour that challenged. Staff told us they had never had to use the techniques taught and they said they tried to talk calmly to people to deescalate people who may be aggressive.

We saw that there were enough staff to attend to people's needs. During each shift there were two support

staff and in the evening there was one waking night staff and the manager was on call. We observed that people were not waiting for support and if they requested support staff responded quickly. The manager showed us their last two months staff rotas and we saw that shifts were always covered if there were absences.

Staff told us they had all received first aid training. If necessary staff said they would call emergency services. The six care plans we reviewed included details of how staff were to respond to people to keep them safe in a crisis or emergency. Records showed that the service recorded checks that the fire alarm was working. Staff told us and records showed where every three months a fire drill was carried out which tested people's compliance for leaving the service during a fire alarm.

The service logged accidents and incidents. We reviewed the incident book and saw two incidents had occurred, the last one reported in December 2015. CQC had been informed as required.

The risk of infection was minimised as staff followed correct preventative measures and staff told us how they did this. We observed staff washing hands and wearing protective clothing when preparing food and when delivering personal care. The service had a local authority food hygiene score of 5 out of 5.

Records showed staff had completed medicines management training in June 2015. We saw appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them. People told us "My medicine is never late." Records showed that people were taken by staff to have their medication administered by a healthcare professional or their GP in good time.

Medicine administration records showed appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.

We saw protocols were in place for staff to follow when medicines were prescribed to be given 'only when needed'(PRN), or where they were to be used only under specific circumstances.. This meant there was information to enable staff to make decisions about when to give these medicines to ensure people were given their medicines when they needed them and in way that was both safe and consistent.

Records showed the manager carried out daily audits to check the administration of medicines was being recorded correctly. The stock balances for medicines were recorded daily and the sample we checked was correct.

The provider had a new medicines management policy and had implemented a system for recording and reviewing medicine incidents. This meant the service was ensuring that medicines were administered safely.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

Hardcopies of the MCA Code of Practice and the Deprivation of Liberty Safeguards Code of Practice were not available in the home. The registered manager confirmed this. There was also no written policy on the MCA in the Home. This meant there were no resources for staff to use to seek information and guidance on the application of the MCA and DoLs.

One person was subject to a DoLs Standard Authorisation with a condition to hold a best interests meeting for family contact. However while the authorisation had been received this information had not been updated on their care plan and the condition had not been met. Where new members of staff joined the service there was a risk that safe and effective care may not be given to this individual as the current position was not recorded.

Another person in the home was assessed as lacking capacity to make decisions when leaving the service and the risks if they went outside the service. This person was under constant supervision and was not free to leave the home. This person may have been deprived of their liberty without authorisation and a DoLs Standard Authorisation was required. The registered manager took action to make the application at the inspection however this had not been previously identified which meant that the person was not being supported to have their freedom.

Out of the five care files only one had a mental capacity assessment and this had been undertaken externally as part of their DoLs assessment. We asked the manager about this and they were not aware that they should be completing their own mental capacity assessments. People's capacity was not assessed in the service and this was a risk to ensure they were supported to make decisions appropriately if necessary.

We saw evidence that staff received yearly training in the Mental Capacity Act 2005 MCA the registered manager had a good understanding of the MCA and DoLs. However, of the four staff we spoke to, only one understood the principles of the MCA and their responsibilities under DoLS.

Care plans contained a place for people to sign but where people had refused it had not been noted whether consent to care had been obtained verbally. Consent for personal care and to take medicines was obtained by staff before the task.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Relatives we spoke to told us they thought staff knew what they were doing. People using the service told us the staff were good.

New staff completed an induction and shadowed a more experienced member of staff before commencing work. Staff told us they were supported to attend regular training and records showed this included Mental Capacity Act and DoLs, Health and safety, Safeguarding, manual handling, food hygiene and infection control, challenging behaviour, first aid and fire safety.

Staff told us they felt equipped in their roles and got sufficient support and training. We reviewed six staff files and saw staff had received supervision with the manager and those who had been at the service for over a year had an appraisal. Staff said "I get to talk about what is good about the work and training I need during supervision."

People were supported to eat and drink healthy amounts. Food preferences were documented clearly in people's care plans. Tea and coffee were available during the day along with snacks. Staff told us the menu was prepared with people at the service and people told us the meals were varied and offered choice. We observed lunchtime and saw that staff helped people cut their food so they could eat independently. Staff were kind and did not rush people to eat. A staff member said to one person, "Eat slowly so you don't choke." One person was monitored as they were at risk of malnutrition. Staff were responsible for recording what the person ate at each meal so any changes could be easily identified. We saw that these logs were completed. People who were diabetic were offered alternatives to sugar and a healthy diet which included salads and fruit. The service also provided food that met the requirements of cultural diets.

Records in people's care files showed that health professionals were involved and people attended health appointments regularly. We could see in peoples care files that the service made referrals and contacted health professionals promptly when people needed medical attention. Staff told us and records showed that they completed appointment records detailing the health professional seen and the outcome. All the people we spoke to told us the appointments they had been to and future appointments they had scheduled which showed the service involved and provided information to them. One person told us "I went to the dentist yesterday." People were also supported to attend annual health reviews for Diabetes and health screening programmes.

Relatives told us that the service kept them informed of appointments so they could attend with their relative.

Good

Is the service caring?

Our findings

A relative told us, "I must say they [staff] are really nice." Another relative said "They [staff] are really kind and compassionate."

We saw that staff showed compassion to people during our visit. This was shown through the interaction style and easy conversation, for example asking them if they were "alright" and "enjoyed breakfast."

Staff told us how they supported one person maintain contact with their husband with a daily phone call. Staff said "[Person] enjoys speaking to her husband it makes her happy, you can see how happy she is afterwards, she's elated."

Staff told us they listened to people if they showed signs of being upset and asked them what was wrong. People's care plans also showed that people at the service would come to staff with their concerns and would be listened to. One member of staff said "I know [person] likes to talk to me and I will spend the time with [person] listening to her."

People's privacy and dignity was maintained. People enjoyed private time in the service and people told us they were going to their bedrooms for time alone. Staff knocked on people's bedroom doors and waited for permission before entering. Staff told us they always ensured people's dignity was respected when personal care was given. One member of staff said "I always ask people if it is ok to give them personal care, I don't just give it. I also tell people what I'm going to do next, I talk to them as opposed to just being quiet which isn't nice."

People learnt skills in the service to help them be more independent. One person said "It's great, I didn't know how to use the washing machine and staff showed me how to use it." We could see this made the person feel happy and staff told us that they helped people learn how to do their washing and they enjoyed it. Staff said to us "when I help [person] do their laundry she says thank you."

People were supported to maintain their religious beliefs if they wanted. We saw in people's care files that people were supported to attend cultural and religious services of their choice.

Requires Improvement

Is the service responsive?

Our findings

People had key workers who supported them in their daily lives and people met with their keyworker to discuss their care plan. Staff knew the people they cared for in detail but this detail was not transferred onto people's care plan. We found that care plans and risk assessments identified needs and risk but they were not personalised.

Care was reviewed every six months or sooner if needs changed. The manager told us how they had reviewed the mobility of one person and moved them to the ground floor. However the assessment to move them could not be seen in the care plan or risk assessment.

Care plans did not always advise on how to manage people's individual traits. For example where someone was known to always ask for a cigarette staff told us how they responded by explaining to them they had just had one and the time they could have another. This technique was not documented in the care plan. During the inspection we observed staff giving people a cigarette earlier and this was not reflected in the care record. The lack of records introduced the risk of inconsistent support and new staff not supporting people in a way that best met people's needs.

People's goals and aspirations were referred to in the care plans but the actual goals and aspirations were not documented. This meant staff could not see whether people had made active progress towards them or if they had changed.

One person asked to go out and was advised by staff it was not their usual time to go. We asked the manager about this and we were told they normally go out in the afternoon. There were no restrictions on this person's freedom so there was no reason why they could not leave the service. After this we noted when the person came to ask again they did go out and told the service where they were going to go as per their care plan. Whilst this was addressed at the inspection, people were not supported in their own decision making. Staff were used to people's routines to the point where if people chose to do something outside of their normal pattern that was refused by the service.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People were encouraged to be involved in the service and we saw this during our visit. For example, one person helped pack the weekly shopping and helped clear the table after lunch. Staff told us this person had previously not engaged in the service but was now actively involved. This helped people feel part of the running of the service and avoided the risk of them feeling isolated. The person told us they enjoyed doing this now. The registered manager also informed us how actively talking and greeting people who were initially quiet meant they were now speaking up more.

The service held an annual Christmas party and took a yearly trip to the seaside and celebrated people's birthdays. This had been discussed in team meetings and relatives told us they had been invited to these events which all helped involve people in activities. A relative we spoke to told us they had spoken with the manager to find out activities their relative could do and purchased tickets for their relative for a cycling competition as they knew that was an activity their relative enjoyed.

We were told people took part in various activities .On our second visit we observed people playing ludo with staff and some people were relaxing in their room or watching television.

We reviewed the complaints policy and the service had received one complaint. This had been responded to appropriately with a meeting with all parties concerned. We spoke to two relatives and one advised that she had raised an issue and the manager had acted appropriately and it was dealt with to their satisfaction.

People told us they were happy and did not want to complain but that they would speak to staff if they needed to. The majority of people said they would approach the manager. Staff were aware of the complaints procedure and advised they would document people's complaints in the communication book and inform the manager so it could be responded to.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives spoke positively about the management of the service. One relative said, "She [manager] is quite efficient " Another relative told us, "If I ask for something she sorts it out. "

One relative said "If she is not at the service the staff call her and she always answers."

Staff spoke highly of the manager and said that "She's a good manager, she is there for us." "She cares about the service users."

The manager said that they are there to provide a service to people and she asked the question "Would I be able to put my family in here? Yes."

The manager did not have a deputy but if they were absent there was a very experienced senior member of staff who could perform duties to run the service safely until the manager returned.

The manager said they were all here to support each other and to learn. Staff confirmed that there was an open door policy and they felt comfortable approaching the manager or a senior member of staff if they wanted to discuss an issue with work or needed support. We saw that regular team meetings took place as well as residents meetings. Team meetings provided the opportunity to learn from incidents talk about how the home was running and the people living there if there were any concerns about their support. Staff confirmed they discussed the need to check people were not carrying lighters to smoke in their bedroom after a recent fire. This was documented in risk assessments and care plans for those who smoked.

We observed staff perform handovers at each shift (unless they had all worked an all day shift with the same staff) where they discussed what had happened and informed the next staff of anything they needed to be aware of.

We saw the service carried out audits to check the quality of the service and these included a recently implemented medicine audit, and checks of daily logs. The manager had previously been auditing all of their loose medication to ensure that what had been dispensed matched what was left over and to check for medicine errors. However, after a recent contracting visit from the local authority they had added a further audit of medicines. This showed the service listened to feedback and implemented it to improve the service.

The manager told us they performed a daily check of the service to see how people were and that the service was clean but this was not recorded. We saw daily charts where staff recorded the household duties that had been completed and checks for the fridge and freezer had been completed.

We noted the only survey that was sent was to people in the service. Feedback was received from all six people. People described the service positively and the questions aimed to find out whether people felt respected, involved and safe in the service. People said "staff listened" "to them and that they "felt safe." One person said in the survey that they had recommended the service to their relative as they liked it so

much. However there were comments where we could not determine that the service had acted on or put in a time frame when this would be met, for example someone had asked for a TV in their room and another person wanted to go on more day trips and play bingo.

Relatives and staff said they did not complete a survey on the service. Due to this we could not see how the service was able to act on feedback given to improve from its staff or people's relatives.

We recommend the service consider guidance on seeking the views of staff and relatives.

The manager had an organised system to locate records and to keep them secure and they sent notifications to the CQC in a timely manner.

The manager was aware of their challenges and how they aimed to address them. They wanted to improve communication with the multidisciplinary teams so that it would improve outcomes for the people who lived in the service. The manager showed how they were always engaging with them to get the relevant treatment or follow ups for people.

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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment did not meet service users needs or reflect their preferences

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided and in accordance with the MCA 2005, where a person lacked capacity.