Runwood Homes Limited

St Michaels Court

Inspection report

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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

About the service
St Michaels Court is a residential care home providing personal and nursing care to 37 people, some of whom may be living with dementia. The service can support up to 86 people. The accommodation comprised a purpose-built property over two floors.

People's experience of using this service and what we found
Poor leadership, management and governance of the service continued to impact negatively on the provision of care. Systems and processes designed to identify shortfalls and to improve the quality of care were not always effective. While some improvements were noted since the last inspection in May 2019, on-going concerns were raised on this inspection. This is the third time in ten months that this service will be rated inadequate overall.

People were exposed to potentially harmful situations due to poor risk management practices. Some risks to individuals were not assessed, and if they were, measures identified to mitigate these risks were not properly documented or followed. Medicine management was unreliable and had deteriorated, despite recent input and advice from a local support agency.

The staffing arrangements for the service were unstable due to a very heavy reliance on agency staff. Recruitment systems did not operate effectively to ensure staff were recruited safely and new staff were not always properly inducted before starting their first shift. Effective training and support to ensure a good standard of staff competency was lacking.

People did not always receive personalised care. New members of agency staff were sometimes unfamiliar with people's care needs and staffing pressures meant they were unable to respond to individuals as required. Care records did not promote personalised care delivery due to the fact they contained inconsistent or inaccurate information. End of life care planning continued to be particularly weak.

People were provided with support to ensure they ate and drank enough. Record-keeping and oversight of these areas of care was not always at the required level though and placed people at risk of harm. People were able to access and benefit from appropriate health care support, but effective and timely care was not always guaranteed.

We were not assured that people were always supported to have maximum choice and control of their lives and that staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported did not support best practice.

There had been an improvement in the provision of group activities and entertainment, and people we spoke with were mostly happy with their care. Staff cared for people with kindness and respect and the premises in which people lived were well suited to their needs.

Rating at last inspection and update
The last rating for this service was Inadequate overall (report published 26 June 2019) and there were multiple breaches of regulation. Prior to this, the service was rated as Inadequate overall (report published 29 January 2019) and in breach of multiple regulations. Since January 2019, we have met with the provider and received monthly action plans, which were reviewed as part of this inspection. At this inspection not enough improvement had been made and the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the very high reliance on agency staff at the home. A decision was made for us to inspect and examine those risks as well as other aspects of care provision.

Enforcement
We identified breaches in relation to safe care and treatment, consent, staffing, recruitment, person-centred care and governance at this inspection.

You can see the action we have asked the provider to take at the end of this full report.

Follow up
The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below

Requires Improvement

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Inadequate

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below

Inadequate

St Michaels Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Two inspectors, an assistant inspector, a specialist nurse advisor and an Expert by Experience attended on the first day of the 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. The second day was attended by two inspectors, an assistant inspector and a pharmacist inspector.

Service and service type
St Michaels Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service did not have a manager registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We obtained feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection

We spoke with four people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff who were employed by the service, including the home manager, a peripatetic manager, one care team leader, four care assistants, a cleaner and a cook. We also spoke with a nurse employed by another home owned by the provider, and who had been asked to cover a shift, two agency nurses and one agency care assistant and two visiting healthcare professionals.

We reviewed a range of records. This included 13 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We received information requested at the inspection and we continued to seek clarification from the provider to validate evidence found. We also spoke with a gp who visits the service and another visiting healthcare professional.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection risks to people's safety were not managed effectively. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● We received concerns prior to this inspection about the management of people's safety and our findings confirmed there remained shortfalls in the provision of safe care and treatment.
● We observed staff using inappropriate moving and handling equipment to support a person to transfer and this placed them at risk of harm. The person's mobility assessment and care records were inconsistent, which increased the risk that staff would not know how to support them safely. A visiting healthcare professional told us they had also raised concerns about the use of incorrect equipment to support a person to transfer.
● We observed a person who was identified as being at high risk of malnutrition and had lost weight in the past few months. When we looked at their records of food intake we saw they did not accuately reflect what the person had eaten. This meant that this person's food intake could not be monitored effectively to identify changes in their health and take appropriate action in response.
● We saw inconsistent records relating to a person's fluid intake and the manager told that us that fluid charts for people at risk of dehydration were unreliable. Staff were therefore unable to properly monitor how much fluid a person at risk of dehydration had consumed in a day and act accordingly.
● One person was assessed as being a very high risk of developing a pressure ulcers. A visiting healthcare professional had recommended this person be repositioned at night-time and wear specific footwear in bed. The person was admitted to hospital four weeks later and it was noted that their pressure areas had significantly worsened. Prior to their hospital admission, there were no records of the person being repositioned or having worn the required footwear, in line with the recommendations made.
● We looked at the records for other people and found that they were not always being repositioned at the required intervals. One person required repositioning every four hours but their records showed intervals of between six and nine hours over a period of four days.

System were either not in place or robust enough to demonstrate that risks to people's safety were always managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They confirmed there would be a prompt review of people's care plans and that all staff would be shown how to use the electronic care recording system correctly.

● There was some oversight of incidents such as accidents and falls and some evidence that action was taken to prevent a reoccurrence of these events.

Using medicines safely
● Medicines were not always being managed safely at the home.
● Medicines prescribed for external application such as creams and emollients stored in people's rooms were not secured, so they could have been accessed by people who could have caused themselves accidental harm.
● Medicines were not always administered as prescribed. For example, one person's medicine needed to be administered 30 minutes before eating to reduce the risk of side effects. We observed that this did not happen.
● For one person a prescribed cream had not been applied for over two weeks because it had not been obtained by staff. Records showed this resulted in the person's skin condition deteriorating.
●There were no administration records for people prescribed topical medicines. This meant we could not be confident people were receiving these medicines as required.
● People receiving medicine via a trans-dermal patch did not have their patch changed at the correct frequency and their patches were not always applied correctly. This created a risk that people did not receive enough of their medicine. People were also placed at risk of developing a reaction if a patch was re-applied to the same site too frequently.
● Poor records regarding medicines prescribed on a 'when required' basis resulted in the potential overuse of medicine for one person.

There were weaknesses identified in the management and administration of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded after the inspection. They started to make improvements to the storage of creams and stated that regular auditing of medicine records would take place.

Staffing and recruitment

We found at the last inspection that there were not enough numbers of staff to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The number of staff available on each shift was not always sufficient to meet people's assessed needs. One staff member told us, "I am not confident that there would be time for call bell checks with the current staffing levels." A visiting professional told us that people were not always seen when they needed help due to the lack of staff.
● On the first day of our inspection we noted that the day shift was not fully staffed. Recent staff rotas indicated there had been further incidences where the number of staff on shift was not in line with the provider's assessed requirements.

●The manager told us that 70 percent of the registered nursing hours and 40 percent of the care hours were covered by agency staff. The continuous and heavy reliance on new members of agency staff exposed the need for higher staffing levels. Agency staff took time to learn their roles and understand the procedures and people's needs. They were not properly inducted and needed regular guidance from more experienced members of staff. This meant that staff on duty worked less efficiently than would ordinarily be expected.

Staffing levels were insufficient and shifts were not always fully covered. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They confirmed that they would review staffing arrangements.

● The selection of agency staff was not robust and put people at potential risk of harm. Records showed that some agency staff worked at the home despite not having undertaken the required basic training. For some agency staff, records showed that their background and suitability to work in the role of carer had not been checked.
● Recruitment processes for permanent staff were in place but were not operating effectively. They did not ensure people employed were of good character and had the necessary competence or skills to undertake the role they applied for.
● Recruitment files viewed did not contain recorded explanations for employment gaps for staff employed. There were also no records of a discussion with a candidate, who was subsequently appointed, relating to a disclosure on their background check.

There were weaknesses identified in the recruitment of staff. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They said they would have closer oversight of recruitment processes.

Preventing and controlling infection
● We identified some poor practices regarding infection control. For example, we observed a dirty item of clothing in a communal bathroom on both days of the inspection. Water jugs were not labelled with a date and time, as required by a recent internal infection protection and control audit.
● Personal protective equipment was available in the corridors and used appropriately by staff.

Systems and processes to safeguard people from the risk of abuse
● There was a risk that safeguarding systems would not operate effectively as the service's safeguarding policy had not been updated to reflect current legislation.
● Staff had received training and were aware of processes to report allegations of abuse. The service had referred allegations of abuse appropriately.
● The people and relatives we spoke to said they felt that staff kept them safe.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Prior to our inspection concerns were raised regarding poor moving and handling practice by staff and two staff members had been suspended as a result of causing people harm. However, staff continued to display poor understanding of correct moving and handling practices.
- The training matrix supplied indicated that 65 percent of the employed members of staff were overdue training in key areas of care. These areas included basic life support, fire awareness, food safety, health and safety, infection prevention and control, manual handling, the MCA, medication awareness, safeguarding, dementia, equality and diversity and fluid and nutrition.
- Staff supervision did not take place. The manager told us there were monthly group supervisions, but these were in fact monthly staff meetings, which were not attended fully. These meetings did not enable an individual review of training or support needs.
- Support for staff was lacking and staff told us they were often unable to access guidance and direction when they needed it.
- Many agency staff were not properly inducted and did not know how to use the electronic care recording system.

Staff were not adequately supported or trained. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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 had the appropriate legal authority and were being

met.

●Records relating to people's capacity to make their own decisions demonstrated a lack of compliance with relevant legislation and procedures. For example, some of the MCA assessment records indicated that an outcome had been reached prior to an evaluation of the person's capacity. Assessments failed to consider whether a person's capacity to decide fluctuated or whether they could make a decision with specific support in place. Records relating to best interests' decisions did not indicate whether any consideration had been given to ensuring the least restrictive option was taken.
● There was inconsistent information regarding people's legal powers of attorney. This indicated that decisions may have been made on behalf of a person using the service by an individual who did not have the legal authority to do so.
● Staff were unclear about some people's inability to make their own decisions. This presented a risk that these people may not have received the support they needed in relation to their care.

We could not be assured that staff always ensured consent to care and treatment in line with legislation and guidance. This placed people at risk of harm. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had met the conditions in a DoLS that had been granted by re-applying for the DoLS within timeframe.
●We saw and heard staff seek consent to care interventions where people required support with personal care.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People living in the home had their needs assessed, however this was not always reflected in people's care plans or care summaries. Some assessments did not produce person-centred care plans with input from people and or their relatives.
●Care was not routinely delivered in line with current legislation and best practice guidance. For example, there were shortfalls in meeting people's moving and handling, nutrition and hydration needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff sought input from healthcare professionals, such as doctors or district nurses, however they often failed to record these visits or conversations in people's records. Where input had been provided, staff did not always monitor the effect of the recommended course of action. For example, staff did not properly assess whether a medication, which had been recommended for one person by the DIST team, actually benefitted that person or not.
●Feedback received about the service from healthcare professionals involved in people's care was mixed.
●People and relatives were positive about their health care support. They received support to maintain good oral health and vision.

Supporting people to eat and drink enough to maintain a balanced diet
● We had concerns about the recording and monitoring of people's intake of fluid and food, their weight and their outputs. We did not find evidence of harm, but the poor records created a risk that people's nutrition and hydration needs were not always acted upon correctly.
● We observed people having their lunch. Most members of staff provided comfort and encouragement and explained to people what they were eating and drinking.
●People we spoke with were positive about the quality and quantity of food provided to them. We saw that

people were offered choice and drinks regularly.
● People's nutritional and dietary needs were assessed, and care planned appropriately. The chef was familiar with people's dietary requirements and sought people's preferences when creating new menus.

Adapting service, design, decoration to meet people's needs
● The environment was well suited to people's needs and the home had many design features that supported the people living there. For example the corridors were wide and light. They contained handrails, items for sensory stimulation and decoration to aide with orientation.
● People's rooms were personalised and there was a homely and comfortable atmosphere. There was a pleasant, secure outdoor area that was accessible to people with reduced mobility.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- We observed a senior member of staff explaining people's care needs to an agency member of staff by way of an induction. They took the agency worker to a group of people who were sitting in the lounge and explained each person's care needs, one by one, so that everyone could hear. This introduction did not promote people's dignity.
- People and relatives told us they were treated with privacy and respect and that staff were considerate and discrete when tending to their personal care needs. One person told us, "They are always respectful and kind. I have the door closed or open as I wish and when my relatives visit."
- People told us that staff sought to promote people's independence. One person told us, "The staff are very good at encouraging you to do things." We observed an experienced staff member assisting a person to walk very slowly with their walking frame. They were patient and interacted with the person, providing explanations and comfort to support them to mobilise as independently as possible.

Ensuring people are well treated and supported; respecting equality and diversity

- Staffing levels and arrangements in the home did not promote kind and supportive care. One member of staff told us that they had written to the manager shortly before the inspection to complain that people's needs were not being met.
- The high reliance on a different agency staff made it difficult to provide continuity of care and for people to develop caring and trusting relationships with staff.
- However, people and their relatives all told us that staff in the home treated them with kindness and compassion. One person told us, "They are good, caring and kind." Another person told us, "They're very good and supportive, I assure you."
- We saw friendly and warm interactions between staff and people using the service. Staff reassured people who were anxious and distressed and responded calmly and with sensitivity.

Supporting people to express their views and be involved in making decisions about their care

- People we spoke with told us that staff involved people in making decisions about their care. One person told us, "The staff always ask, they never tell you to do something." However, people's care records were not always person-centred and did not demonstrate how they were involved in making decisions about their care.
- We observed staff supporting people to express their views, for example, by ensuring they had eye contact and that people could easily hear them.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

At our last inspection the provider had failed to ensure people received care that was individualised to them.This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9

● Concerns were raised prior to our inspection that care was not meeting people's individual's needs and preferences. Our findings confirmed that the systems and practices in place did not promote person-centred care delivery or good continuity of care. Many staff did not know people's current personal needs and preferences because they were not shown how to access their care records or given uptodate information about them.
● An agency worker told us when they started their first shift, "I wasn't told about people or how to use the electronic care record system." Another member of staff told us they had been instructed by the manager not to attend shift handover but just to start their shift.
● One person developed bruises on both legs and on their face between May and August 2019. A safeguarding investigation concluded it highly likely the bruises were caused by a member of staff using poor moving and handling techniques. During the inspection we saw staff continuing to use inappropriate moving and handling equipment to support this person to transfer.
● One person, who was at risk of falling, regularly walked into another person's room at night-time and woke them up. Staff had not put in place measures to keep the person safe from falling at night-time or to reduce the likelihood of them disturbing the other person. As a result, the person who was visited regularly told us they needed to move bedrooms.
● Another person did not have the correct sized wheelchair because the recommendations of a health care professional had not been acted upon. They had developed red patches on their legs due to this.
● There was no evidence of activity provision for people requiring meaningful engagement in their rooms. We found a lack of care planning to ensure a person who was nursed in bed avoided becoming socially isolated. The person was at risk of exhibiting certain behaviours if they didn't socialise, and this behaviour was evident for large parts of our inspection.
● A staff member told us, "Staffing impacts on care. For example, things are getting neglected like shower routine, washing teeth, cutting nails – the finer things."
● End of life care plans continued to be absent in some people's records and those we saw were poorly

completed and gave little guidance on people's wishes for this stage of their life.

Systems were not in place to ensure people received person-centred care. This placed people at risk of harm. This was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The provider responded immediately after the inspection. They confirmed that all staff would be shown how to access people's records and that people's care plans would be reviewed.
Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their
carers.
● People had communication care plans in place but these were basic and did not clearly indicate people's needs. Due to the additional concerns identified about access to records, we were not assured that this standard was always met.

● People were supported to maintain relationships with people that mattered to them.
● Two wellbeing leads had been appointed and their role was primarily to ensure people were able to undertake activities and enjoy social events that were of interest to them. People spoke positively about the wellbeing leads and the group activities.

Improving care quality in response to complaints or concerns
● An agency member of staff told us they raised concerns about staffing arrangements with management however these were not acted upon promptly.
● We saw that five relatives had made complaints, which were responded to appropriately.
● People and relatives told us they felt comfortable raising concerns with staff.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the provider had failed to demonstrate good governance. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There had been a further change of management since our last inspection and the service continued to operate without a registered manager in post. The home had been led by four different managers since December 2018 and the inconsistent leadership had destabilised the service. We continued to lack confidence that the service could make and sustain the improvements required.
● In the absence of a registered manager, greater oversight of the service should have been in place by the provider as they have overall legal responsibility and accountability for how the service is run and for the quality and safety of the care provided.
● The service had not made sufficient progress to improve their rating since the last inspection. Multiple breaches of regulation were identified at this inspection inspite of significant recent input from local support agencies. The service had also followed a home improvement plan since December 2018 but this had failed to achieve its stated aim.
● The current manager had been in post for three months at the time of our inspection. However, there was no clear and effective strategy in place to ensure robust oversight of care provision and to drive service improvement.
● The manager failed to ensure regular and effective auditing, checks and reviews were undertaken relating to people's care. As a result, we found that accurate, complete and contemporaneous care records were not consistently maintained for the people who used the service, as required by law. There was widespread under-reporting of care interventions by staff and entries made by staff in people's daily notes were often inaccurate.
● The manager was also unaware of the inadequacies regarding agency staff selection and induction and they failed to provide the required training, support and guidance for staff.
● Issues identified in health and safety audits were not always followed up on. We also noted that the moving and handling equipment in use in the home was overdue an inspection.

Systems were either not in place or robust enough to ensure effective governance and drive service improvement. This was a continued breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They confirmed that action would be taken to ensure the induction of agency staff and to improve the auditing and accuracy of service records.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The service lacked cohesion and there was very little sense of team-working or collaborative, streamlined working practices. For example, the home manager thought certain responsibilities were carried out by other members of staff when they were not.

● The manager told us, "Agency staff don't have the same stake in the home." However, we found staff lacked a sense of ownership and accountability throughout the service due to a management style which did not promote inclusivity amongst the workforce or give clear direction.

● Most staff members we spoke with told us they did not feel particularly valued or that their views mattered. Some members of staff told us they did not trust the managers. This did not reflect a healthy and open culture, where staff would be comfortable to raise concerns either internally or externally where they felt this to be required.

There were weaknesses identified in the working culture within the service. This placed people at risk of harm. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager had met with people and relatives in relation to the ongoing problems at St Michael's Court.

● Staff were committed to caring for people as well as they could.

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

● People and their relatives were mostly positive about the management and some told us they had been able to provide their feedback. One relative and resident meeting had taken place since our last inspection.

● Staff meetings were held on a monthly basis, but staff gave us mixed feedback on how much they were involved in developing the service. From the concerns identified, we could not be assured that these meetings were effective.

Working in partnership with others

● The service worked in partnership with health care professionals, the local authority and the clinical commissioning group. Staff did not, however, fully adopt and implement the advice provided to them.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always received person-centred care and their needs were not always fully assessed. Care plans were not always accurate or fully detailed. 9(1) (3)(a) and (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations Need for Consent Staff were not all aware of the need to ensure consent to care and treatment in line with legislation and guidance. 11 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always adequately assessed and mitigated. Medicine management placed people at risk of harm.

12 (1) (2) (a) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance. The provider had failed to implement systems and processes that effectively monitor the quality of service provision. 17 (1) (2) (a) (b) (c) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The recruitment of staff was not always robust. 19 (1) (2) (3)

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 Requirement 18 HSCA RA Regulations 2014 Staffing Staffing levels were insufficient and shifts were not always fully covered. Staff were not adequately trained or supported. 18 (1) (2) (a)