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St Michaels Lodge

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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on the 5, 7 and 13 April 2017 and was unannounced. St Michaels Lodge provides accommodation for up to 12 people living with mental health needs. At the time of our inspection there were six people living in the home.

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

The provider had failed to implement appropriate quality assurance systems which had resulted in the shortfalls that we found during this inspection failing to be identified or acted upon. We also found that the home had not been adequately maintained and the provider did not have plans in place to address the maintenance of St Micheals Lodge.

People could not be assured that they would receive their prescribed medicines. We found that there was an excess stock of people's medicines which the provider told us meant that people had not received these medicines. There were insufficient processes in place to ensure that all prescribed medicines had been given.

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

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

There was a task led culture in the home. We found a number of examples of poor care where people were not treated with dignity and respect. We also found examples whereby changes in people's care and support needs had not been responded to appropriately. People's care was not always based upon their preferences and feedback from people about their care and support was not sought.

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

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

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

Risks to people had been assessed however, staff did not always follow the plans of care that were in place to keep people safe.

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

Is the service effective?

Requires Improvement

The service was not always effective.

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

People did not always receive the support that they needed to access healthcare professionals.

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

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

Is the service caring?

Inadequate

The service was not always caring.

The approach of staff in providing people's care and support was not consistently caring.

People were not always referred to respectfully and could not be

assured that they would receive person centred care.

People's preferences in relation to their care and support were not acted upon.

Is the service responsive?

Inadequate

The service was not responsive.

People were not involved in planning or coordinating their care and their preferences were not always considered by staff.

People did not receive the care that was outlined in their plans of care.

Changes in people's care and support needs had not been responded to appropriately by staff.

Is the service well-led?

Inadequate

The service was not well-led.

Systems were not in place to monitor the quality of the service. Shortfalls were not being identified and addressed appropriately.

The home had not been adequately maintained and plans were not in place to improve the environment.

There was a task led culture whereby people living in the home were not valued and their views not sought or acted upon.

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.

This inspection took place on the 5, 7 and 13 April 2017 and was unannounced. The inspection was undertaken by one inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of mental health services.

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

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

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

Requires Improvement

Is the service safe?

Our findings

had been received by the home on people's individual Medication Administration Records (MAR) charts. When we checked the number of tablets in stock and compared this to the number of tablets recorded as having been administered and we found that there was an excess of tablets held in stock by the home for each of the medicines that we counted. This meant that people had not received their prescribed medicines however, staff had recorded that they had been administered.

For example, one person was prescribed medicine to help them sleep at night. Staff had recorded that they had received 48 tablets from the pharmacy and had administered 12 tablets. However, there were 37 tablets in stock which means that on one day this person had not received their prescribed medicines. Another person was prescribed medicine to prevent the occurrence of stomach ulcers. Staff had recorded that they had received 28 tablets from the pharmacy and administered 24 however; eight tablets were in stock meaning that on four occasions this person had not received their prescribed medicines.

The provider had no systems in place to monitor the administration of people's medicines and therefore was unaware of the medicine errors that we found during this inspection. The provider did not monitor the administration of people's medicines to ensure that they had received their prescribed medicines safely. The provider told us that there was no system in place to audit the medicines that had been received, administered or recorded as having been administered within the home. The homes medication policy stated that two staff were to administer all medicines to mitigate the risk of errors occurring however, for long periods of the day only one member of staff was on duty and people's MAR showed that only one member of staff had administered people's medicines in April 2017. The provider had not reviewed their medicines policy to reflect the reduced staffing levels within the home. The failure of the provider to implement systems to ensure that people received their prescribed medicines safely placed people at the risk of harm.

We bought this to the attention of the provider who acknowledged that there were shortfalls in the way in which people's medicines had been managed and that people had not received their prescribed medicines. The provider told us that they would introduce a system to audit the administration of people's medicines to ensure that people had received these safely.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

There were sufficient numbers of staff working within the home to maintain people's safety however, there were not sufficient numbers of staff working to facilitate meaningful engagement and activities with people. One member of staff told us "We don't really do activities now because there is only one member of staff. When we used to have two staff we used to do some activities." Staff also told us "One member of staff is enough to be working to get everything done. We have time to talk to people." Staffing levels within the home had been reduced because a number of people who had lived at St Micheals Lodge no longer resided there. The provider told us that they closely monitored staffing levels and worked within the home during

the week and that the staffing levels were sufficient to meet people's needs. If people had planned medical appointments the provider ensured that staff were available to support people to attend these appointments. However, we found that on a daily basis there was only one member of care staff working and this meant that staff were unable to facilitate activities within the home to aid people's sense of wellbeing. We observed that this member of staff was focussed upon preparing food, drinks and providing people with their cigarettes and was unable to facilitate any meaningful engagement with people.

Risks to people had been assessed, however staff did not always follow people's plans of care to ensure they remained safe. Staff had not always read people's plans of care and were not always aware of the measures that had been implemented to maintain people's safety. However, people told us that they felt safe living in the home. One person told us "I feel safe here, it is very nice." Another person told us "I feel safe here. I can come and go as I please." The plans in place that had been developed to mitigate the risks to people were reviewed monthly and staff handovers were used to share information amongst the staff team about any changes to people's care and support needs.

People were supported by staff who were knowledgeable about potential risks and who knew how to protect people from harm. Staff had received training in safeguarding people and the staff we spoke to had a good knowledge of how to recognise the signs that someone may be at risk and the steps to take to escalate concerns to the registered manager or other outside agencies. One member of staff told us "If I ever had any concerns I would talk to the manager or someone outside of the company like CQC"

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

Requires Improvement

Is the service effective?

Our findings

People's capacity to consent to their care and support had not been considered by the staff providing care. There were a number of restrictions in place upon people within the home however, their capacity to consent to these restrictions had not been assessed and there was no evidence that the provider had followed the principles of the Mental Capacity Act 2005 (MCA) in developing people's plans of care. For example, people's bedroom doors were locked in the day to prevent them from accessing their bedroom. One member of staff told us "[Person's] bedroom is locked in the day, I suppose for safety reasons. I have never asked." The provider told us that one person's door was locked to maintain their safety due to the risk of arson; however, this person's capacity to consent to this restriction had not been assessed.

A number of people living at St Michaels Lodge smoked cigarettes. Staff controlled people's access to cigarettes and ensured that people living in the home only smoked one cigarette per hour. Staff told us that they supported people to manage their cigarette consumption because without this support people would chain smoke and would not have sufficient funds to purchase cigarettes. However, we observed people asking for cigarettes and being told that they had to wait by staff. The provider told us that they had developed these plans of care because they were in people's best interests however, we could not see that any formal assessment of people's capacity had been completed to show that they lacked capacity to manage their own cigarette consumption and therefore required staff to place restrictions upon their access to cigarettes in their best interests. Staff had received training in the MCA however did not recognise that the support they were providing to people, for example when managing the consumption of their cigarettes constituted a restriction. Staff did not consider their training in relation to the MCA and apply their learning on a day to day basis.

The Mental Capacity Act 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.

The provider had not assessed people's capacity to consent to their care and support and had implement plans of care that had resulted in restrictions being placed upon people however, had not followed the principles of the MCA to ensure that these were in people's best interests. This constituted a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

Staff did not always respond appropriately to changes in people's needs. One person asked a member of the inspection team to find their dentures for them. We asked staff where this person's dentures were and they told us "[Person] hasn't had them for five or six weeks. We don't know where they have put them. They are still managing to eat though." Staff also told us "[Person] isn't registered with a dentist so we can't book them an appointment." This person had been without their dentures for a number of weeks and staff had not taken action to support this person to obtain new dentures. People had been supported to develop

hospital passports to provide information for medical professionals about people's care needs and preferences in the event that they are admitted to hospital. The provider supported people to attend their planned medical appointments with their allocated GP's and psychiatrists.

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

People received the support that they needed to eat and drink. Staff prepared the meals within the home and people told us that they enjoyed the meals within the home. One person told us "The food is nice. We have a main meal every day at midday." There was a menu on display within the main dining area and staff knew people well and considered their preferences when developing the menu and preparing meals within the home.

Inadequate

Is the service caring?

Our findings

People were not always treated with dignity and respect. During this inspection we found that people were being supported to shave with an electric shaver that was shared amongst all of the people living at St Michaels Lodge. There was a sign on the medication cabinet in the main lounge to remind staff to wash the shared razor after it had been used at the weekend. The provider told us "It is a shared razor. Some people have a wet shave but they can't afford an electric razor so people share it." A shared razor does not promote dignified care and does not promote a culture whereby people are valued or treated with respect. We instructed the provider that it was not acceptable for staff to use a shared electric razor to support people to shave and the provider assured us that this razor would no longer be used. However, the provider and staff team had not acknowledged that a shared razor was not a dignified or respectful way in which to support people to shave. This highlighted the culture of the home whereby people's experience of receiving care and support and their quality of life was not considered by the provider or staff working in the home.

We observed that within the kitchen cupboard there were two shelves to store tea and coffee cups. One shelve was labelled "for staff" and another shelf was labelled "residents". Staff made all of the hot drinks within the service and people had separate cups to the staff. We asked the staff working why this was however; they were unsure and unable to explain this practice. This highlighted the culture of the home whereby people were not valued or treated consistently respectfully by staff. We observed people asking staff for a cigarette. On a number of occasions staff failed to respond to or acknowledge people's request and left the room without acknowledging people who had asked for a cigarette.

People were not able to access their bedrooms freely because the provider had not replaced people's bedroom keys if they were lost or damaged. This continued to highlight a culture whereby people were not valued. People's bedroom doors were locked during the day. The provider told us that this was because the front door was unlocked during the day so people's bedroom doors were locked to keep their possessions safe. We asked staff if people had keys to their bedroom so that they were able to access their room in the day should they wish to. Staff told us that people did not have keys. When we fed this back to the provider they told us "Not everyone has a key. Some people's keys are lost and they are expensive to replace so if people want to go into their room they need to ask staff." The provider had not considered that this practice restricted people's ability to move freely amongst the home or impacted upon people's sense of wellbeing and dignity because they were unable to access their bedroom independently without first asking staff to unlock their door for them.

People were not encouraged to express their views about living in the home or the care and support that they received. The provider told us that they used to obtain feedback from people living in the home through residents meetings however, these meetings had stopped. The provider told us that this was because "People didn't want to attend them and when they did they didn't provide any feedback." This meant that people were unable to express their preferences about how they spent their time, or provide feedback about the care they received.

Senior staff knew people living in the home well. People were relaxed and comfortable in the presence of

staff and senior staff were able to describe people and their life histories and clearly knew people well. During our inspection we observed positive interaction between senior staff and people however, this quality of interaction was not consistent amongst the care staff. One member of staff that we spoke to had not read people's plans of care and worked independently in the home. We observed limited interaction between people and this member of staff and interaction was largely task led in the absence of senior staff.

People were enabled to maintain relationships that were important to them. One person told us, "My girlfriend comes to visit me every week and we spend some time in the lounge together." Another person told us, "Sometimes my family come to visit me and we spend some time together in the home." People were able to invite their friends or partners to spend time with them in the home without any form of restrictions being placed upon them by the provider. People were able to spend time with their relatives or visitors in any area of the home.

Inadequate

Is the service responsive?

Our findings

People did not always receive their planned care and the care that people did receive was not sufficiently individualised or reflective of people's individual preferences. Staff had not read people's plans of care and were not familiar with the care that people required. For example, one person had a care plan in place to support them to manage their laundry and mitigate the risk of them misusing chemicals in the home. This plan of care stated that staff should support the person to wash their clothing each day and search their bedroom for chemicals. A care agreement was in place with this person to show that they had agreed for care staff to search their bedroom for any chemicals that may be present. We viewed this person's bedroom and found that it smelt very strongly of chemicals. One member of staff told us "[Person] is independent. They do their own washing in their bedroom. I have never been in their bedroom and I don't do their washing. I was told not to do anything for them." This member of staff also told us "I haven't read anyone's care plan. The other staff tell me what to do."

The provider told us that the domestic staff searched this person's bedroom each day for chemicals however; we found that the hours that the domestic staff work had been reduced and therefore they did not work in the home every day. The provider had recently redesigned the garden to remove areas of undergrowth where chemicals could be hidden. However, on a day to day basis this person was not receiving their planned care to support them to manage their laundry and access to chemicals because staff were not aware of or following this person's plans of care. This meant that this person was placed at risk of harm because they were not receiving the support that they needed to reduce their contact with chemicals that may be harmful to their health.

Staff had noted that one person's mobility had decreased because of the impact of a chronic health condition and that they were struggling to use the stairs to access their bedroom. The provider told us "[Person] has now moved to a downstairs room and shares with [Person]. They had to move because they were struggling to use the stairs." We observed that although this person had changed bedrooms their personal belongings were still in their previous bedroom. When we spoke to this person and the person that they were now sharing a bedroom with both individuals expressed a preference to have their own bedroom. One person told us "I don't like it." The provider told us that they had changed this person's bedroom because they felt that it was in their best interests, that they often forgot that they had changed bedroom but their family members were aware and had agreed to the change in bedroom. We spoke to this person's relative who told us that they did not know they had moved into a shared bedroom but did know that they had changed rooms in the home. The provider had not liaised with any external health professionals or commissioners to consider if changing this person's bedroom was the best strategy to support them with their mobility difficulties and we noted that there was a stair lift present within the home however, this could not be used as it had not been serviced. Had the stair lift been maintained adequately this may have negated the need for this person to move bedrooms.

Feedback from people using the service was not sought or acted upon. The provider told us "We used to do residents meetings but no one ever raised anything or wanted to attend so we stopped." No other effective strategies to obtain formal feedback from people within the home had been adopted by the provider. The

provider was not taking people's views into account when delivering care and support to them.

Staff told us that they did offer people activities however; people chose not to participate in these. One member of staff told us "We used to do activities but we don't anymore now there is only one of us working." During our inspection we observed that there were no activities available for people and that staff made no attempt to engage people in activities. One person asked a member of our inspection team if they could watch a video. We asked told the provider that this person wished to watch a video however, the video player was not working. One person told us "I just listen to my radio really and watch TV. There isn't anything else to do." The provider told us that they had offered people activities but that they turned these opportunities down. The provider and staff had not reviewed how they offered people activities or attempted different strategies to engage people in meaningful activities to aid their well-being.

This constituted a breach of Regulation 9(1), (3)(b) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person Centred Care.

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

Inadequate

Is the service well-led?

Our findings

An effective system of quality assurance had not been implemented by the provider. This inspection highlighted shortfalls in the management of people's medicines that the provider was not aware of. The provider told us that they had not implemented any form of quality assurance system in relation to the management of people's medicines and this had resulted in the shortfalls that we identified failing to be addressed.

The provider had failed to implement a system of audits to consider the cleanliness and maintenance of the home. During this inspection we identified a number of areas that were in need of renovation that the provider had failed to identify, or to develop strategies to resolve. The provider had recently reduced the number of hours that domestic staff worked and we found that a number of areas of the home were dirty. For example, in the main lounge the chairs were stained and had ingrained dirt that was present.

The provider told us that they were aware that a number of areas within the home were in need of redecoration and maintenance however, they had not developed a systematic approach to resolve this. We found that the main lounge had a hole in the wall and ceiling. We also found that carpets and flooring throughout the home were stained and damaged. The provider told us that they had not identified funds for works to the building or developed their business plan for the financial year. This meant the provider could not provide any assurances that the home would be maintained adequately.

People living in the home did not have the opportunity to provide meaningful feedback about the care and support that they received. For example, during this inspection people told us that they were not happy sharing a bedroom and the provider was not aware of this feedback. When we raised this with the provider they dismissed this feedback and told us that people were confused and that they felt people were happy to share a bedroom. People were supported by staff to complete annual questionnaires to provide feedback about the care and support that they received, however, this system was not effective at gathering honest feedback from people and had not identified the issues that we found during this inspection.

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

There was a culture within the home whereby staff focussed upon the tasks of providing care rather than considering people's preferences and providing consistently personalised care and support. For example, drinks were provided at set times, staff did not provide people with a choice of drink because they felt that people would always have the same drink. People were not encouraged or enabled to complete meaningful activities to aid their sense of well-being. People were not valued by the provider or the staff providing their care and support. For example, the provider felt that it was acceptable that one person lived without their dentures although this person had said that they wished to use their dentures. Changes to people's plans of care were made without meaningful engagement with people receiving care and support; for example one person had been moved to a different bedroom although their personal possessions would not fit into their

new shared bedroom.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive their planned care and the care that people did receive was not sufficiently individualised or reflective of people's individual preferences. This constituted a breach of Regulation 9(1), (3)(b) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person Centred Care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to consent to their care and support had not been considered by the staff providing care. Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People could not be assured that they would receive their prescribed medicines safely. This constituted a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had failed to implement a system of audits to consider the cleanliness and maintenance of the home. People living in the home did not have the opportunity to provide meaningful feedback about the care and support that they received. The provider had not implemented any form of quality assurance system in relation to the management of people's medicines and this had resulted in the shortfalls that we identified failing to be addressed. This constituted a breach of Regulation 17 (2) (a) (e) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.