St. Michael's Care Ltd

St Michael's Home

Inspection report

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Tel: 01217079697

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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?	**Inadequate**

Summary of findings

Overall summary

St Michael's Home is a two storey building and provides personal care and accommodation for up to twenty one older people. On the day of our visit there were 15 people in the home.

The inspection took place on 10 January 2017 and was unannounced.

During our last comprehensive inspection on 18 May 2016, we found the provider was not fully meeting the standards required. We identified two breaches of the Health and Social Care Act 2008. This was in relation to care and treatment not always being provided in a safe way and there being insufficient monitoring of the health, safety and welfare of people. Improvements were required included medicine management and ensuring care plans were accurate to support staff in managing risks related to people's care such as nutritional risks.

We asked the provider to make improvements and they sent us an action plan stating they would take the necessary action to comply with the legal requirements. During this inspection we found insufficient action had been taken to maintain the improvements made.

The service did not have a registered manager. 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. It was of concern that there had not been a registered manager in post since November 2015.

There was a senior care staff member who was in charge on the day of our visit and they were carrying out some of the management duties in the absence of a manager. The senior care staff member had had not been allocated enough management hours to do these duties effectively. People were complimentary of the senior care staff member who supported the inspection process. There was a 'compliance' manager who had been appointed by the provider to provide some additional management support to the home but this did not include care duties.

Sometimes staffing arrangements were not effective to ensure people's needs were met. People told us they had to wait to be supported. Staff knew about risks associated with people's care and there was a system in place for them to communicate changes to each other. However, people's care and support needs were not always accurately recorded in care plan records to make sure there was a consistent approach to managing them by staff. This included risks associated with moving and handling people and supporting people with behaviours that challenged staff and others.

People told us they did not feel involved in planning their care and had limited opportunities to discuss any changes or how liked their care and support to be provided. Some social activities were provided but people felt they were limited in what social activities they could do. Information about people's interests

and hobbies was not always available to staff to help them provide person centred care.

Where people were at risk of poor health, due to not eating or drinking enough, there were processes to monitor their food and fluid intake to help ensure their nutritional needs were met. However, records were not always clear to show instructions given by health professionals were followed. People told us they were provided with sufficient drinks and they sometimes liked the meals but were not always given a sufficient choice.

Some staff had completed some training considered essential to meet people's needs but there were gaps in training that needed to be addressed. New staff had not consistently completed induction training or been given access to the policies and procedures they were required to follow to ensure they worked safely when supporting people. Staff had limited knowledge of the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards so that they understood how these impacted on people. Some staff had attended staff supervision meetings with a manager to identify their training and development needs but these had not taken place regularly for all staff.

Overall, people received their medicines as prescribed but there had been occasions when the prescribing instructions had not been consistently followed to ensure people's healthcare needs were met.

Staff knew about some of the different types of abuse and how to recognise potential abuse and understood their responsibilities to report this to a manager. However, care staff had been instructed not to assist people with personal care at mealtimes. This practice meant the immediate needs of people were disregarded and their needs were not met.

There was a lack of systems and processes to monitor the quality of the service and drive improvement within the home. Satisfaction surveys and meetings with people had not recently taken place. Audits were not fully effective in ensuring areas for improvement were identified and acted upon.

There was a complaints procedure on display so that people knew how to raise a formal complaint but there was no central record of complaints so the provider could monitor them and ensure they had been appropriately responded to.

Incidents within the home had not consistently been reported to us as required so we could be assured appropriate action had been taken to keep people safe. This included health and safety incidents related to the environment.

People told us they felt safe living at the home because it was secure and they liked the staff.
The provider carried out a range of recruitment checks before staff started work to ensure staff employed were safe and suitable to work with people who used the service. People said staff were respectful towards them and we saw staff were caring in their approach and were mindful of protecting people's privacy and dignity. People told us staff asked them before supporting them with personal care.

Visitors were made to feel welcome at the home at any time to help people maintain relationships with people important to them.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we have told the provider to take at the end 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 consistently safe.

People said they felt safe. Staffing arrangements were not always effective to ensure people were safe. Staff knew about risks associated with people's care but these were not always clearly recorded or managed to ensure people's ongoing health and wellbeing. Staff understood their responsibility to report any potential abuse or concerns about people's wellbeing. There were some practices associated with medicine management that needed to be improved. Recruitment records were clear to confirm safe processes had been followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not consistently completed training to ensure they had the right skills and knowledge to support people effectively. Staff understood about gaining people's consent but the principles of the Mental Capacity Act (2005) were not always followed. Staff did not have a working knowledge of Deprivation of Liberty Safeguards (DoLS). People sometimes enjoyed the food provided but had limited choices. People had access to health healthcare professionals to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People were supported by staff who were caring in their approach and people were positive in their comments about staff. Staff respected people's privacy and dignity, and promoted their independence where possible. People were supported to maintain relationships with those who were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive person centred care that met their needs and preferences. Care plans contained information to

support staff in meeting people's basic care needs. However, people's social care needs were not always supported to help maintain their health and wellbeing. People had limited involvement in planning their care. There was no clear overview of complaints for the provider to assure themselves these were being managed effectively and to demonstrate lessons had been learnt.

Is the service well-led?

Inadequate

The service was not well led.

People's experiences of living at the home were not always positive due to staffing arrangements not being sufficient. Quality monitoring systems were not effective in ensuring actions were taken to ensure people experienced good quality care and support consistently. Staff felt supported by other staff team members but felt the lack of a consistent manager in the home had impacted on the effective running of the home. There had been no registered manager in post since November 2015.

St Michael's Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 10 January 2017 and was unannounced. The inspection was carried out by two inspectors and an 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.

We reviewed the information we held about the service including the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority commissioning officer to find out their views of the service. The information they shared was similar to what we knew about the service.

The provider had not been asked to complete a Provider Information Return (PIR) on this occasion.

We spoke with six people who lived at the home, two visitors', five staff and the compliance officer appointed by the provider to support the effective management of the home. We observed the care provided to people and reviewed the care plans of three people in detail. We also reviewed other records to demonstrate the provider monitored the quality of service such, audit checks, accident and incident records, health and safety and medicine records.

Requires Improvement

Is the service safe?

Our findings

During our inspection on 18 May 2016 we identified improvements were needed to manage people's medicines safely and manage risks related to people's care such as nutritional risks. Care plans and risk assessments did not always contain accurate information.

During this inspection we found some improvements had been made. This was to care plans and staff understanding of nutritional risks and how to manage them but further work was required to fully address these areas.

We found risks to people's safety had not always been fully assessed with clear actions to address them. For example, we saw one person could not walk and we were told they had not been able to walk since they came out of hospital. Staff were aware the person needed the assistance of a hoist and to be transferred from a chair to wheelchair. However, the care plan stated the person could walk with a frame. The falls risk assessment had not been updated in December 2016 when the person had returned to the home. The November entry stated the person would be assessed on their return from hospital but this had not happened. We saw a "Fire risk assessment" for this person that stated, "[Person] is able to mobilise with a Zimmer frame steadily with 1 x carer can exit the building like this safely." This was not accurate, the incorrect information meant the person may not be supported appropriately in an emergency situation. Information about the person in the care plan did not reflect how the person would need to be supported to keep them safe and meet their needs. There was no health care assessment showing the person had been assessed as needing a hoist. A staff member confirmed this had happened in hospital and the person had their own personal sling. The senior care staff member told us that they knew some of the information in care plans was not correct and they planned to rewrite them. They commented, "Risk assessments need more detail. I know that, but we know what the risks are."

Staff told us about a person whose behaviour at times was challenging towards others. Staff were not sure how to manage this behaviour to keep the person and themselves safe. Staff told us there were no specific instructions in the person's care plan to follow and when we checked we found this was the case. One staff member told us, "[Person] can be really unpredictable; [Person] scares me a bit. I have told [senior care staff member], they have taught me how to calm [Person] down but it's not written anywhere." They went on to tell us about an incident that had happened which had unsettled people and said "Thank god [senior care staff member] was here to calm them down." There was no behaviour chart to show, at a glance, the pattern of this person's behaviour so this could be shared with health professionals if needed. We asked staff what they did if the person shouted or showed signs of becoming challenging. They told us they would encourage the person to go to their room to calm down and distract them with a cup of tea or snack. However, because there were no clear instructions for staff, it meant they may not provide a consistent and safe approach to this person's care.

The compliance manager told us following our visit that information in people's care plans had been reviewed and amended to accurately reflect their needs.

We identified an infection control risk regarding one person and observed strong odour in this person's room. We identified from the person's care plan record, that their personal care routine may be the cause. However, there was no clear plan about how to manage this risk to maintain the health and safety of the person as well as staff supporting them. We were subsequently informed the carpet had been cleaned.

We identified one person was at risk of choking due to the way they consumed fluids so they needed the support of staff to drink. Staff recorded the amount of drinks the person consumed and we were told these records were checked. However, we identified the volume of drinks they consumed was not checked to ensure this was sufficient to maintain the person's health and wellbeing. Nutritional records did not contain a target of fluids the person needed to help ensure staff gave the person a sufficient amount.

When we looked at medicine management we saw one medicine record showed staff had administered more tablets to a person that were actually available. We queried this and were told that a staff member may have signed for two tablets but only given one which would have meant the person received a reduced dose to that prescribed. The senior care staff member told us they would follow this up with the staff member concerned.

One person was prescribed a skin product that was to be applied four times a day to help control their itchy skin. When we looked at the Medicine Administration Record, this was only being applied twice a day. Staff had completed a body map that showed scratches and redness to the person's skin. We were told the person scratched their own skin due to itchiness suggesting the reduced application of the creams had contributed to this person's discomfort.

This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff knew about their responsibilities to protect people from harm and were able to tell us about some of the different types and signs of abuse. One staff member told us, "I would report safeguarding straight away if nothing was done, I would phone the council. I had training a few years ago." Another staff member told us, "Abuse is neglect, for example, not washing people properly, leaving people in wet pads so they get sore skin." Staff said they had completed training in protecting people from the risk of abuse and would report any concerns to the manager to ensure any risks to people were managed. However, staff had not recognised that by not assisting people to go to the toilet when they needed to, this could be considered as abuse. We were told by four of the six people we spoke with that people had to wait to be assisted to the toilet. During our visit one person told us, "The lady next to me …. at 3.55pm she rang the buzzer and asked to go to the toilet. The carer said she couldn't go because 'it's tea time'. She was in distress and crying. They finally came at 5.15pm, I know because I looked at the clock on the wall." Another person told us, "I don't think you get the attention at the time you need it. Like when I want to go to the toilet. Yesterday I had lunch and asked to go to the toilet. It took them 20 minutes to take me. The carer said people had to finish eating first." This practice meant the immediate needs of people were disregarded and their needs were not met.

One staff member told us, "If we do things correctly we can meet their needs." They gave an example of "correctly" as taking people to the toilet at set times such as before lunch. However, this meant people were not supported to go to the toilet when they needed to.

Not responding to people's needs in a timely manner could amount to neglect. At the time of our visit there was no manager in post so staff were reporting concerns to the senior care staff member. We asked the senior care staff member why people were not assisted to the toilet when needed. We were told there had been a previous management decision for staff to assist people to the toilet before meals. This decision had

been made so staff were available to support people as staff had limited time to provide support during mealtimes. However, this decision had not been based on people's needs and it was acknowledged by the senior care staff member and compliance manager this practice needed to be reviewed.

We found people were not protected from improper treatment.

This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment – Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The compliance manager told us following our inspection visit that safeguarding training had been arranged for all staff to help them increase their knowledge and understanding of how to safeguard people from potential harm or abuse. They also told us, "Staff are now not working to a regime and the resident's needs are being met to suit the residents."

People told us they felt safe at St Michaels because the home was secure and they liked the staff. One person told us, "Yes very safe. The people are very nice…. The people make me feel safe, very reassuring." Another told us, "Quite safe. It makes me feel safe that no-one can just walk in."

Care plans contained some risk management plans for staff to follow to keep people safe. For example, records confirmed during the assessments of people's care needs, equipment people needed to support them safely had been considered. We saw most people were sitting on pressure cushions to prevent the risk of them developing sore areas on their skin from sitting for prolonged periods of time. Where people needed walking frames to support them to walk these were accessible and placed in front of their seat. One person who had been assessed as high risk of developing pressure sores had a specialist mattress to help minimise the risk of these developing.

During our visit we saw at certain times of the day staff were task orientated with little time to spend with people. In the absence of a registered manager, the senior staff member on duty was undertaking some management tasks which meant they had limited time to spend providing care to people. They understood their responsibility to manage any risks to people's health and safety but had limited time to manage both roles effectively. The provider had not ensured they were given sufficient supernumerary time to carry out these duties in addition to the care duties they were expected to complete.

People told us there was not always enough staff to manage their needs and this resulted sometimes in them having to wait for support. One person told us, "I think there should be more staff definitely." Another person told us, "Barely enough staff, they have difficulty in covering shifts. I've seen people needing help and not getting it." A third person said they felt there should be a staff member in the lounge all of the time but this did not happen "quite a lot of the time". We saw staff entered and left the lounges as they carried out their duties during the day so they were not necessarily in communal areas all of the time.

A visitor felt more staff were needed. They told us "I don't think there is enough staff. There is often no one in the laundry and domestics don't work every day." They were concerned about care staff being taken away from caring for people to complete these duties. Duty rotas showed there was a domestic person employed five days per week, however, it was not clear how many hours they worked or if they completed any laundry duties.

Staff told us they felt pressured sometimes to meet people's needs. They explained there were at least five people who needed two care staff to support them which meant they had limited time to support others. One staff member told us, "Sometimes there is not enough staff. It depends who you are working with."

They said some staff were better than others and this impacted on the tasks they needed to complete.

We were told by the provider prior to our inspection that the staffing levels for the home were four care staff in the morning and three in the afternoon. On the day of our visit we saw these numbers of staff on duty. At night there were two care staff on duty and night staff told us this was sufficient unless there was an emergency situation. As there was no manager available, it was not clear who would be 'on-call' and who could be contacted in an emergency situation. The duty rotas for the home did not make this clear.

The compliance manager explained some of the staffing issues raised may be due to the deployment of staff in the home and they would look at this further. Following our inspection visit they told us about action they had taken to address staffing concerns. They told us, "Staff shifts are more structured and there is more presence from staff. We are currently recruiting staff …… We are taking on apprentices from our local college who will be trained as required and this will ensure that there is enough staff to meet the resident's needs."

Medicines were stored securely and we saw these were usually administered to people safely. We checked the records of medicines that required increased storage and care when administering. Records confirmed these medicines were used safely.

Most staff had completed training in the safe management of medicines and we saw one staff member administer eye drops in a safe manner. They explained to the person when the drops were going into their eyes so they could prepare for each drop.

Each person had their own medicine administration record (MAR) which contained their photograph to reduce the chances of medicines being given to the wrong person. MAR's showed people received their medicines as prescribed with the exception of the application of creams and lotions. Most of the creams and lotions we saw contained instructions for them to be used "as directed". There was no clear information about what advice the doctor had given in relation to these to ensure they were used appropriately and were effective. The compliance manager advised us following our visit that contact had been made with the doctor to find out how medicine prescribed "as required" was to be used.

Where people had been prescribed medicines to be given PRN (as required) we did not see a PRN protocol in place stating how the medicine should be managed. For example, where pain relief tablets or indigestion remedies had been prescribed, instructions were not available so that all staff understood how they were to be used. This was important to prevent the risk of too many tablets being given which could impact on the person's health. One person told us that when they requested their PRN medicine during the evening or night, staff did not provide this is in a timely manner which left them is some discomfort for long periods of time.

Some medicines had not been dated when opened. This was important because they contained instructions for them to be discarded after 28 days. The senior staff member who had managed the medicines for people assured us the medicines in use were in date and stated they knew this because of the delivery date. They acknowledged the dates should have been recorded and stated they would ensure this happened from now on.

Staff said they were not allowed to start work until their recruitment checks had been completed. The provider carried out police checks and obtained appropriate references to ensure staff were safe to work with people who lived in the home. A staff member confirmed this, they told us,
"I did provide references, I know they were checked. Disclosure and Barring Service (DBS) clearance was

done before I started." The DBS is a national agency that keeps records of criminal convictions.

The provider had taken measures to minimise the impact of unexpected events such as fire risks. People had individual evacuation plans on their files so it was clear to staff and the emergency services how they would need to be supported in the event of an emergency. However, as we had found a record that was not accurate, we could not be assured they were all up-to-date.

Requires Improvement

Is the service effective?

Our findings

People said they felt staff had the skills required to meet their needs. They told us, "I'm quite happy that they are competent" and "I wouldn't say it's excellent, it's reasonably good (staff knowledge and skills)."

We found new staff had not always been given the opportunity to have a detailed induction to the home and were not consistently supported with initial training to carry out their roles safely. Some staff told us they had been reliant on training they had achieved from their previous care roles or on staff from within the home to show them how to meet people's needs. One staff member told us, "On my first day I was asked to bathe someone who I now know needs two carers to assist them. I just had to get on with it." Another staff member told us, "I had no induction and no shadowing (working alongside more experienced staff). On my first day I was shown around the home, that's about it. I have learnt everything off the other staff. I watched how they did things." They went on to tell us, "It was daunting when I first started, I didn't know what to do. It was hard, but the other carers helped me to find my feet."

There was a system in place to implement the Care Certificate. To obtain this, staff are assessed against a specific set of standards. Staff have to demonstrate they have the skills, knowledge, and behaviours to ensure they provide compassionate, high quality care and support. We saw records for one staff member showed elements of their training had been signed off by the manager as completed. However, these records did not demonstrate the person had been assessed as competent to carry out their role following completion of the training.

Staff told us they had been reliant on other staff to help them when unsure about supporting people with certain aspects of their care. One staff member told us they were asked to use a hoist with another staff member and had not completed training on how to do this. They told us, "I had never used a hoist before, staff showed me how." We found there were variances in training staff had completed. For example, one staff member told us, "I have had training; it's good, face to face. Training taught me to use a hoist, I am confident that I move people safely."

Following our visit the compliance manager told us action was being taken so that all new staff had an induction to the home and completed the necessary training.

We looked at the training matrix record for staff which listed all the staff in the home and the training they had completed. This showed gaps in all training considered essential to meet people's needs such as moving and handling people, infection control and food hygiene. The compliance manager told us this record was not accurate and they had made contact with the training provider to obtain the necessary information to update the record. Some staff had attained a National Vocational Qualification (NVQ) in care to help build on their skills and knowledge to support people effectively. The compliance manager told us following our inspection visit that all staff had been asked to complete "mandatory" training to address their training needs.

One staff member told us they had not been spoken with about the policies and procedures of the home.

When we asked how they knew about how to support people safely, they told us they had learnt this from working with other care staff. This meant staff may not have a consistent or safe approach to supporting people.

Despite some staff not having completed essential training, our observations throughout the day showed staff who had completed training had learnt from this. For example, we saw staff wearing protective clothing when supporting people at mealtimes to help prevent the spread of infection within the home.

Staff observations following training could not always be demonstrated to confirm staff were competent and safe to provide care to people. Some staff had attended supervision meetings with the previous manager to discuss their staff development needs and training they needed. One staff member told us, "I do have supervisions, they happen from time to time. I can talk about how I am feeling, the managers do listen. I really do try my best, to provide good care." The compliance manager told us following our inspection that senior care staff would be completing training so they could carry out supervision meetings with care staff regularly.

People told us they were provided with sufficient drinks and they sometimes liked the food. People had access to drinks from a drinks trolley at set times and people told us if they asked for drinks outside of these times they were provided. One person told us, "I have regular drinks. Whenever I ask, they bring it. I have too much sometimes. I don't get snacks at all. I'd be telling lies if I said the food was good. It's adequate." Another person told us, "The food varies; we haven't had a proper chef for a long time. Overall it's fair, not brilliant."

People were able to have some choice of meals although at times these choices were limited. One person told us, "About six times in the last month we haven't had a choice due to a shortage of staff." Another said, "Most times you get a choice. What you choose you usually get." On the day of our visit we saw people's food choices were limited. At breakfast time, porridge and toast was provided to people but no other options were offered. Porridge and/or toast was placed in front of people entering the dining room. One person had asked for toast and tomatoes and was provided with their choice. We checked what breakfast options were available and established a food order had not been made which meant people's choices were limited and there were no options of other cereals to offer.

The compliance manager told us following our inspection they were in the process of recruiting a cook to improve the catering service provided.

At lunchtime the main meal was served. People were asked if they wanted blackcurrant or orange juice to accompany their meals. There was a choice of two meal options but two people did not want the hot food options available. They were offered and provided with a sandwich. People's comments about the lunchtime meal included, "That looks nice" and "It tasted good." We saw lunchtime was a social part of the day with most people in the home sitting down to eat together. Two people had their lunch in the lounge and staff told us one of these people needed to be supported to eat. Where people needed support to eat and drink, this was provided to ensure their nutritional needs were met. We saw a staff member sat at the same level of the person they were assisting to eat. The staff member took their time so the person was not rushed and they ensured each spoonful was given at a pace the person was comfortable with.

Some people's meals were blended or mashed so they were soft and easy to swallow to prevent the risk of them choking. Where people were at risk of poor nutritional health the advice of health professionals was sought such as from a Speech and Language Therapist (SALT) or dietician. It was not always clear that the advice given was followed. For example, for one person records stated the person should be given "normal"

diet and fluids on a teaspoon, fortified foods (calories added) and mousse. The cook was not aware of what 'fortified' meant. However, staff told us cream was added to drinks and we saw cream on the tea trolley in use. One staff member told us, "I put cream in [Person's] coffee and butter in [Person's] potatoes." They knew the person was at risk of losing weight. However, they were not sure all staff knew this. Records of food and drinks provided for people at risk did not show if they had been fortified and did not demonstrate this was being done consistently. This information was fed back to the senior care staff member and compliance manager to enable this to be addressed.

Training records showed the majority of staff had completed training on nutrition so they could support people with their meals and drinks safely. One staff member told us, "I have had nutrition training. It was good because some people are at risk of choking. It taught me why people need thickeners." We saw signs around the home about people "choking" and what staff should do if this happened."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The senior care staff member understood their responsibility to comply with the requirements of the MCA. They knew they needed to provide care in a person centred way and promote people's independence. People said they were asked about their care before it was provided and were not restricted from doing what they wished. One person told us, "I go to bed when I like. I don't feel restricted in doing what I want to do." We saw records on people's care files for "consent to care" and "consent to photographs" but these had not been signed by people to confirm their agreement.

Staff told us they asked people before giving care and would offer encouragement if they refused and ask them again later to ensure their needs were met. One staff member told us, "I always ask people if I can help them. If they refuse I listen. [Person] can refuse; I leave them for few minutes and then ask them again." We asked them what they would do if someone continued to refuse support; they told us they would ask another care staff member to help them. This showed they knew to try a different approach to ensure the person's needs were met.

The MCA and Deprivations of Liberty Safeguards (DoLS) require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. We were told people in the home had capacity but two applications had been submitted where restrictions on people's liberty had been identified. This demonstrated there was a lack of understanding around DoLS as applications are only required to be submitted for approval where people lack capacity to make decisions themselves. We did not see best interest decisions had been made where people had capacity and staff felt people's safety was at risk. For example, people leaving the home unattended. One staff member told us about a person with capacity who regularly attempted to leave the home but would not be safe to do so. They stated they put the lock on the door to prevent them from going out which meant they were restricting the person from doing what they wished.

People told us they were able to access healthcare professionals when needed to support their needs. One person told us, "If you need a doctor you let them know and they arrange it. I have to ask them for a chiropodist. They arranged my dentist appointment." Another told us, "They arrange the doctor, it's usually

the same day or the next, they look after me quite well there. The chiropodist comes about every eight weeks. The optician comes quite regularly. I don't need the dentist but they do come."

Good

Is the service caring?

Our findings

We asked people for their opinion of the care provided at St Michaels Home and the staff that provided support. People said the staff were "alright" and were respectful towards them. Comments included, "The majority of staff are kind and considerate. No trouble there, quite respectful" and "They treat me alright." One person told us "They are all very nice. Respectful, yes. They can take a while to take me to the toilet, it seems general."

When staff explained how they supported people, it was clear they knew people well. One staff member told us, "I look at old photos with one person; it brings back their memory which makes them smile. I always look after someone how I would want to be cared for."

We observed staff were caring in their interactions with people and provided help and assistance to people in a patient, calm and reassuring way. For example, we observed one person being transferred from a wheelchair to their seat in the lounge. The staff member explained to the person what was about to happen in a caring way so the person felt at ease when assisted.

People were supported to maintain relationships with those who were important to them. Relatives and visitors were welcomed into the home and we saw them visiting people during the day. One visitor told us, "I find the staff very good, polite and nice." Another visitor said, "I have never seen anything that has worried me, the staff are really caring."

One person told us their relative called them every day and staff made sure they were given the telephone to they could speak with them which they said they enjoyed.

People felt staff maintained their privacy and dignity. One person told us, "No concerns when they shower me." Another person told us how staff encouraged their independence. They told us, "They give me a bath, I do a lot myself, they encourage that." Generally our observations confirmed staff respected people's privacy and treated them with dignity. One staff member told us, "Dignity is making sure people are dressed properly so they don't have their skin on show."

Two people told us they did not like the way they were addressed by staff sometimes as they had been called "darling" and "luvvie" as opposed to their names which they did not like. However, this had been mentioned to staff by people and they said this had improved.

Requires Improvement

Is the service responsive?

Our findings

People told us they had not been involved in planning their care or in reviewing their care plans to ensure the care they received was in accordance with their needs and preferences. Comments included, "We all have a care plan, it's never been discussed with me. I've had no involvement with my care at all" and "No involvement at all. I've never seen my care plan or discussed it."

Following our last inspection care plans had been reviewed with a view to them containing more person centred and information that was up-to-date. We found that whist the overall content of care plans had improved, information in some care plans continued to need updating. For example, in the care file for one person who was fully mobile it stated they had a "crash mat" and "sensor mat" next to the bed although the person had not had any falls. The use of the sensor mat would have alerted staff when the person stepped on it. There was no clear explanation as to why these mats were being used. One staff member gave an explanation for the mats being used but there was no information in the care file about the risks the staff member explained. When we asked another staff member why a sensor mat was being used they told us, "Good question, I don't know why." This practice did not demonstrate person centred care.

Although care plans were not always up-to-date or accurate, overall staff knew about people's care needs and how to support them. Staff told us they knew about changes to people's health by observing them because they knew people well and could tell if their needs had changed. Staff also told us they shared information about people at handover meetings at the beginning of each shift. One staff member told us, "At handover we talk about how people are feeling and any changes that we need to know. Handover is a good thing; we are prepared for the shift by knowing how people are." Records of these meetings also included other information such as dressing changes and planned visits from health professionals.

There was a communication book to also aide effective communication between staff and this was used to good effect. People's appointments were recorded as well as any changes in people's needs that staff on other shifts may need to know about. We saw the senior care staff member wrote in the book they had contacted the pharmacy to request a thickening agent needed for one person's drinks. They told us, "I have written it down so the next senior doesn't reorder."

Although some social activities were provided, people felt, they were limited in what social activities they could do. They could only recall two group activities taking place in addition to religious services held at the home. People said they had not been asked about hobbies and were not able to pursue hobbies they previously did at home. Some people were not satisfied with the level of activities and entertainment provided. Comments included, "They don't do a lot of activities. They have a man who does some keep fit things; he now comes once a week. They don't do a lot else" and "I just read, I can't do much else. A man comes once a fortnight to do exercises. Monthly we play bingo and that's about it. We do have a Methodist service here." One person said, "There is no entertainment here at all just the telly. They have never asked about my hobbies."

During our visit we looked to see how people spent their day and if they were engaged in any social

interaction with staff or each other. The atmosphere in the home was quiet and calm in between mealtimes. We saw one person playing a card game of 'Snap' with a staff member which they appeared to enjoy for a short period of time. Most people were seated in the lounge and some were watching the television. Staff usually only spoke with people when they provided care or support. People had limited opportunities to be socially stimulated by spending time with staff or participating in activities of interest they enjoyed. Staff acknowledged the importance of speaking with people and providing social stimulation. One staff member told us, "Saying 'hello' to people can often brighten their day." Another told us, "People have only been out for appointments. I think some people would like to go to the shops or out for a walk. It would be nice if we had a garden so people were not always cooped up. I think [Person] gets bored." The compliance manager told us following our inspection that action was in progress to address social activities for people. They told us, "We will be supporting residents to access the community and to interact in activities that are tailor based for their individual needs."

Care plans contained some information about people's life history such as names of family, friends, which schools they went to and what jobs they did. However, this information was not always completed in sufficient detail to support staff in talking with people about things of interest to them. For example, in one person's file there was a "This is my life" form with questions about previous employment, happy memories and dislikes but these sections of the form were blank. When we asked a member of staff member about this person, they were not aware of the person's interests or past history.

People said they didn't have any major complaints or anything they needed to complain about. Two people spoken with had made complaints in the past, one said their complaint had been managed to their satisfaction, the other who had a reoccurring concern said "They just fob me off." One person told us they had made a complaint about the food and this "did improve for a while."

There was a complaints procedure on display on the notice board in the home so that people and visitors had access to the information they needed if they wished to escalate their concerns. A visitor told us the manager who had left had been approachable to discuss concerns.

Inadequate

Is the service well-led?

Our findings

During our last inspection we identified effective systems were not in place to monitor the quality and safety of the service provided. This included not having effective systems to check medicines and care plans to ensure staff were responding effectively to people's changing needs. There was also no registered manager in post. During this inspection, we found there had been some improvements to care plan records and medicine management but these were ongoing. There were additional areas we identified to need improvement.

There was no manager or registered manager at the home when we carried out our visit. The home had been without a registered manager for over a year. Managers who had been recruited to the position had not been retained by the provider. This meant people had not benefited from the stability of a long term manager to enable the ongoing effective management of the home. People knew there had been changes in the management and spoke both positively and negatively about the impact this had on the home. No-one was aware of the reason for the sudden absence of the most recent manager leaving.

The compliance manager told us they were in the process of recruiting a new manager and an interview had been arranged. However, we were subsequently told following this person's appointment they did not stay and a senior care staff member would be taking on the role of acting manager.

At the time of our inspection, a senior care staff member was the person in charge. They told us they worked permanently as a care worker but they were also required to complete some management duties. Whilst there was a compliance manager in the home to provide management support when required, we observed the senior care staff member was very rushed due to attempting to complete both caring and management duties. They had not been given sufficient supernumerary time (time not working as a care staff member) to complete these additional duties.

People told us staffing arrangements were not always effective to ensure people experienced consistent care and support in ways they preferred. Staff were at times task orientated and people told us staff spent little time with them. One person told us, "I would like them to sit and talk to me sometimes." Another told us, "They should stop two or three staff chatting to each other all the time instead of talking to residents or taking people to the toilet."

People told us they had not been involved in decisions relating to their care plans and were not given opportunities to be involved in decisions about the home at regular 'resident' meetings. They told us meetings rarely took place to give them opportunities to provide their views about issues related the running of the home. They said when they had provided their opinions on issues, nothing changed. One person told us, "We haven't had a resident meeting recently…. I haven't noticed any changes as a result of them." Another told us, "We don't have residents meetings now. The last time was when [a previous manager] was here. She didn't stay long. Nothing really changed from the meetings anyway."

One out of the six people we spoke with recalled completing a satisfaction survey about the home "a while

ago". The compliance manager told us there had been no satisfaction surveys carried out recently to obtain people's opinions of the care and support they received. We were told people were spoken with on a one to one basis to identify and act on any concerns or issues they had. However, one person told us, "The home is never discussed with me."

The provider had not fully met the requirement to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. There had been recent incidents in the home that compromised people's safety such as problems with the telephone system, and water that we had not been made aware of. This meant we had been unable to check safety measures were in place to keep people safe. There had been a flood in one bedroom and we saw this had caused damage to a ceiling near an electric light. This had not been recorded in the maintenance book to ensure it was checked and safe. We saw the room was no longer in use. The compliance manager told us staff had promptly informed them of the incident. They advised the maintenance person would be making repairs the week following our visit. We discussed the issue of reporting incidents with the compliance manager to ensure actions were taken to notify us of incidents as required.

Although a staff training record had been developed, there were gaps in staff training that had not been promptly addressed to ensure staff skills and knowledge was kept updated. The provider's policies and procedures had also not been made available to new staff consistently. This meant they may not be aware of their responsibilities due to not having clear information about what was expected of them. One member of staff told us they had learnt what to do from working with other more experienced staff. The compliance manager subsequently advised us of training planned to ensure all staff could update their training.

Quality audit checks were carried out but sometimes checks were not sufficiently detailed or structured in a way that improvements could be identified. For example, an audit of medicines was carried out to make sure the amount available each day was correct and medicines were available for people. However, the audit had not picked up some staff administration errors such as the incorrect frequency of skin applications. Where errors had been identified, such as gaps in signatures on the medicine administration records, it was not clear what action had been taken to address them to prevent them happening again. We could therefore not be confident lessons were learnt when errors were found.

We were told concerns or complaints were written directly into people's records as opposed to a central record. This meant information was not easily accessible to the provider to enable them to have an overview of concerns received by people so they could assure themselves issues of concern were fully addressed.

We saw some quality monitoring checks were carried out such as "Keyworker" checks. These took place weekly and included checks to make sure bedrooms were tidy and people had sufficient stocks of toiletries. However, we noted in one room there was a very strong unpleasant odour that would have made it uncomfortable for the person sleeping in this room. In two other rooms we viewed, there was a set of broken drawers and a broken light over the wash-hand basin. This suggested audits were not sufficiently detailed to ensure issues needing attention were swiftly acted upon.

There were some health and safety checks that had not been completed such as checking the hot water temperatures on a regular basis to make sure they were running at recommended levels. One person told us sometimes they had no hot water. They commented, "What drives me mad is no hot water which happens frequently." A staff member told us, "The water is hit and miss, I don't think it's hot just warm."

The Local Authoirity had identified there was an insufficient safe food management system in the home and

staff were in need of food hygiene training.

There was an overall lack of effective systems and processes to make sure people received a consistent and safe quality service. We had also identified this at our previous inspection. Actions taken had not been sufficient to ensure the provider met the required standards.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

The compliance manager told us following our visit that the acting manager appointed would "attend a course" to ensure that quality monitoring was effectively carried out within the home.

Since the last inspection, care plans had been reviewed so they contained more detailed and up-to-date information. Whist staff had a good knowledge of people's needs; work was ongoing to ensure all care plans were up-to-date and accurately reflected people's needs.

Staff were positive about the senior care staff member who was supporting them in the absence of a registered manager. One staff member told us, "[Senior staff member] gets thing sorted out. They are so knowledgeable, just amazing." They went on to tell us how the senior staff member encouraged them to work together. Another staff member told us, "The team are good, we work together well."

The compliance manager had been employed by the provider to help support improvements at the home. This demonstrated the provider had identified the need for staff to be supported and the need to improve standards within the home. Staff told us when the latest manager had left, the compliance manager had been available in the home every day to support them. One staff member told us, "The team are good, we work together well. I would tell [compliance manager] if I needed more help." Another staff member told us, "Now we have not got a manager, [compliance manager] will be here more often." This demonstrated the compliance manager was accessible to staff to support them through the improvements required.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks associated with their health, safety and welfare because risks were not fully assessed to ensure care and treatment was always provided in a safe way. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not sufficient to protect people from improper treatment. Regulation 13 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to manage risks, monitor the service and drive improvement were not sufficient to ensure the health, safety and welfare of people. Regulation 17 (1)

The enforcement action we took:

Issue a warning notice