St. Michael's Care Ltd

St Michael's Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Michael's Home is a residential care home providing personal care to up to 21 people. The service provides support to older people, some of whom have a diagnosis of dementia. At the time of our inspection there were 15 people using the service.

People's experience of using this service and what we found
At our previous inspection of St Michael's Home we identified serious shortfalls in the provider's oversight of the service which had resulted in people not always receiving safe care and treatment.

At this inspection we found improvements had not been made and people continued to be at risk. This included risks related to people's health and care needs as well as environmental risks. The home was not clean and infection control was not effectively managed. Medicines were not managed safely which placed people at risk of harm. The systems and processes for learning lessons were not robust. The provider had increased staffing levels however people and staff did not think there were enough staff to provide safe care. Staff had received training about how to protect people from the risk of abuse.

Systems to assess, monitor and improve the service were not effective in identifying shortfalls and securing improvements. Opportunities to learn lessons and make improvements to the service had not been taken. There was a lack of effective leadership and there was not a registered manager in place at the time of our inspection. Staff did not always work effectively with other health professionals to ensure people received appropriate care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 June 2022).

At our last inspection we found breaches of the regulations in relation to safe care and treatment and the governance of the service. The provider completed an action plan after the last inspection to tell us what they would do and by when to improve.

At this inspection, we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to the quality of care people received and the management of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Michael's Home on our website at www.cqc.org.uk

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We have found breaches in relation to safe care and treatment and good governance at this inspection.
Please see the action we have told the provider to take at the end of the full version of this report.
The overall rating for this service is inadequate and the service is therefore in special measures. This means we will keep the service under review and will re-inspect within 6 months of the date we published this report to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question, we will take action in line with our enforcement procedures. This usually means we will start processes that will prevent the provider from continuing to operate the service.

For adult social care services, the maximum time for being in special measures will usually be 12 months. If the service has shown improvements when we inspect it, and it is no longer rated inadequate for any of the 5 key questions, it will no longer be in special measures.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.
Details are in our well-led findings below.

St Michael's Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 3 inspectors. Three inspectors visited the service on the first day of inspection and 2 inspectors returned on the second day of inspection.

Service and service type
St Michaels's Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
Both days of this inspection were unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We observed people and their interaction with staff and each other throughout the inspection visits. We spoke with 2 people, 1 relative and 4 health and social care professionals to gain their views. We also spoke with 8 members of staff including 6 care staff, interim manager and an agency manager. We viewed a range of records held within the service, this included 7 care plans and multiple medicines records. We looked at 2 staff files in relation to recruitment. We requested a variety of records relating to the management and oversight of the service, including staff training records, risk assessments, policies and procedures and quality assurance audits but these were not all provided to us.

After our first day of inspection, we wrote to the provider about our concerns for people's safety and asked urgent action was taken to mitigate risks to people. We were not assured about the action taken and returned to the service to assess if the required improvements had been made. On the second day of inspection, we found people continued to be at risk and we took action to suspend the regulated activity at the service and people were moved to other care homes in the local area.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection we have rated this key question inadequate. This meant people were not safe and were at risk of avoidable harm.
Using medicines safely

At our last inspection we found the provider had failed to ensure people received their medicines safely. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulations.

● Medicines were not always stored safely and securely. Medicines were stored in a lockable trolley which was kept in the manager's office. The manager's office was not locked, and we saw the keys were left on top of the trolley which would allow anyone to access the medicines.
● Controlled drugs were stored in a locked cupboard in the manager's office but the keys to this cupboard were not stored securely which could allow people to access these. Controlled drugs are medicines which require specific storage, monitoring and recording of use. This is a legal requirement and is to prevent the misuse of medicines which can result in dependence. We found some controlled drugs were stored in the lockable cupboard which had not been recorded in the controlled drugs book therefore we were not able to know if the correct amount remained. There were controlled drugs stored in the lockable cupboard which were not recorded in the controlled drugs book and were prescribed to residents who no longer lived at the home. The provider has a legal responsibility to ensure all medicines accompany a person when they move to another service or to arrange disposal of the medicines with a pharmacy if they are no longer required.
● Information to support staff to administer medicines safely was not always available. Medicine Administration Records (MARs) were not always available and handwritten records had been made by staff. These records did not contain dates of when medicines had been given and some people had more than 1 record which could mean staff could give people more than the prescribed dose.
● For people who were prescribed medicines to be taken when required there was not always person-centred information for staff to follow to ensure these were given as prescribed. During the morning hand over a senior member of care staff reported 1 person had been "Screaming about being in pain in their legs." No action had been taken to address this person's pain. Later that morning whilst a member of staff was giving people their medicine another member of staff told them the same person had "Threatened to throw themselves down the stairs unless an ambulance was called." An inspector intervened and asked the senior member of care staff to review this person where they identified symptoms which could indicate a blood clot in the person's leg which could become life threatening. The staff member called an ambulance for the person and following review from the paramedics it was identified the person had a history of pain in their legs and was prescribed medicine to relieve this but had not been administered for 10 days since they were admitted to the home.
● A person was prescribed a medicine which affected the rate of their heart. To administer this safely staff were required to monitor the person's heart rate before giving the medicine. This instruction was not recorded on the MARs or care plan and staff were not checking the heart rate before administration. If a

person received this and their heart rate was already under a specified limit it could cause chest pain, shortness of breath and dizziness which would require the person to access medical treatment.
● Two people were prescribed medicines which required a nurse to administer. Staff confirmed they did not administer those medicines as they had not been trained to do so. A district nurse visiting the home confirmed that neither person was under the care of the district nursing service. This meant these people had not received the medicines they were prescribed.
● Staff who administered medicines had not all received training to do this safely. Staff did not always display the skills and knowledge to administer medicines safely, one senior member of care staff had to be repeatedly prompted by an inspector to change their gloves between administering medicine to people. This included placing tablets into people's mouths for them. If the member of staff did not change their gloves in between people, it would increase the risk of transmitting infection and risk cross contamination of medicines.
● Staff had not been monitoring the temperature of the room medicines were stored in so we could not be assured that these had been stored at the recommended temperature. Medicines stored at the wrong temperature may not be effective at their use.
● Prescribed creams and gels were not labelled with the date they were opened. This meant staff were not aware of the date the medicine should be disposed of and risked people receiving medicines which were no longer effective.

We found the provider had not ensured people received their medicines safely. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection including the cleanliness of premises
● Risks to people were not assessed and managed safely. Care plans had not been created for everyone living at the home which meant staff did not have the information to provide safe care. A person had been living at the home for 10 days on our first day of inspection and staff did not have any information about their health needs and risks relating to their care. This person was prescribed medicine to reduce the risk of blood clots. Staff told us they did not know why the person was prescribed the medicine or their medical history. This meant staff could not effectively monitor the person's health.
● Where risks had been identified, actions had not always been taken to ensure people's safety. A person's care plan stated they were at risk of choking and required a modified diet to reduce this risk. Staff responsible for preparing food told us they had not received training about modified diets. We saw the person had been given food which would increase their risk of choking. Care notes documented the person was regularly given food that would place them at a risk of choking.
● Staff did not seek appropriate medical advice when a person showed signs of illness. During a handover meeting on our first day of inspection a senior member of care staff stated a person had been unsettled during the night and had regularly gone to the toilet but "had not passed any urine." Another member of staff identified that this could be due to a urinary tract infection but no additional checks of their temperature or heart rate were made to identify possible signs of infection. Care staff did not contact other medical professionals for advice. Emergency medical professionals were attending the home for another person living there. During their visit they identified the person with the potential urinary tract infection required admission to hospital because they were "slumped, drowsy and not rousable." This deterioration of health had not been identified by any care staff and if not treated could have posed a life-threatening risk to the person.
● Staff were not maintaining contemporaneous care notes and we found multiple inaccuracies and gaps in documentation relating to the care provided including pressure area care, dietary intake and continence care.

● Personal emergency evacuation plans were not all up to date or accurate about who currently lived in the home and people's moving and handling requirements in an emergency.
● Staff did not have a thorough understanding of how to protect people from the risk of disease or infection. We witnessed staff carrying used continence products through the home without the use of clinical disposal bags which increased the risk of people being exposed to bacteria and unsanitary products.
● The home had many areas which were damaged, and which could not be thoroughly cleaned, this increased the risk of infection.
● Areas of the home did not have hot water, this meant people and staff could not wash their hands when necessary or after using the toilet. This increased the risk of infection.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● There was not a robust system in place to analyse incidents and ensure there was any actions or learning to be considered.
● The provider had not taken sufficient action to make improvements and address risk following feedback from previous inspections by CQC and the local authority.

Staffing and recruitment
● Prior to our inspection concerns had been identified by the Local Authority that there were not sufficient staff to provide care, following this feedback the provider agreed to have another member of staff work on each shift. The provider maintained this staffing level during our inspection.
● Despite the increased number of staff, people who lived in the home told us there were not enough staff. A person told us "There are not enough staff. Two have left recently and the others are all working so hard, they should get an award and pay rise because they work so hard."
● Safe recruitment processes were followed. The provider ensured pre-employment checks were completed before staff began working at the service which included checks with the Disclosure and Barring Service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk from abuse
● Systems were in place to protect people from the risk of abuse and harm.
● People felt safe within the home and said they could speak to staff if they needed help. One person said, "I'm happy here, the staff do their best and look after me."
● A relative confirmed they were happy with the care and support and felt people were safe in the home.
● Staff had received training to identify signs of abuse and how to report it. Staff told us they would raise any concerns with the interim manager.
● Where safeguarding incidents had occurred, referrals had been made to the local authority safeguarding team and notified to CQC.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● Where people lacked the capacity to make their own choices and decisions we found capacity assessments, and best interest decisions were completed.
Visiting in care homes

People were supported to have regular visits with people who were important to them.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection we have rated this key question inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
At our last inspection we found the provider had not ensured that systems were established or operated effectively to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider remained in breach of regulations.

- This is the third inspection of St Michael's Home since November 2021. For the last 5 inspections the provider has continually failed to meet the required standards and achieve a rating of good in the well-led domain or as an overall rating. The provider's continued lack of oversight meant they had failed to take action to demonstrate compliance with regulations and make the necessary improvements to demonstrate people always received safe, effective support. This placed people at risk of harm and demonstrated lessons had not been learnt.
- The provider failed to ensure systems were in place to keep people from harm. The provider did not have an effective and robust system in place to ensure there was oversight and analysis of incidents, accidents, and people's behaviours.
- The provider did not have an effective system in place for audits and monitoring. The interim manager was not able to provide us with any audits or evidence of monitoring the quality of service. This meant the shortfalls we found had not been identified by the provider or interim manager and therefore no improvement in quality had been made.
- There was not a registered manager in place at the time of our inspection. A manager had registered with CQC in November 2022 however left the home on 07 March 2023. At the same time senior members of care staff resigned. Although the provider had employed an interim manager these changes had resulted in inconsistency and a lack of oversight. The interim manager informed us a new manager had been appointed.
- The provider could not demonstrate continuous learning and improvements. The shortfalls identified at this inspection concluded the quality and safety of the service had deteriorated since the last inspection.

The provider had not ensured there were effective, robust systems in place systems to assess, monitor and improve the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The lack of improvement at the service and the inherent risks of poor governance meant people were not always supported to achieve good outcomes.

● Systems were not in place to capture people's views on the quality of care. However, during our inspection, a person and a relative was complementary of the care staff provided.

● Staff told us they were proud of the support they provided people and they thought the management of the home was improving.

● Communication systems were not always effective in ensuring staff were kept informed of key changes. On the first day of our inspection neither of the senior care staff working were aware of the name of a person who had been living in the home for over a week.

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

● We could not be assured the provider always complied with the duty of candour as they were not able to evidence how they had responded to incidents or accidents that had occurred.

● The provider had displayed the rating from our last inspection in the entrance to the home so people could see this information in line with regulatory requirements.

Working in partnership with others

● Prior to our inspection we were contacted by external health and social care professionals who were concerned the provider did not always work in partnership with them and this meant they could not be assured people were receiving the support they needed.

● During our inspection nurses who worked for the local authority were working in the home to support staff to improve processes of how people received their medicines and to increase their knowledge of how to provide good quality care. A nurse told us staff were receptive to the advice given.