

## St Anne's Community Services

# St Anne's Community Services- Doncaster

### Inspection report

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### Ratings

#### Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Good** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

We inspected St Anne's Community Services- Doncaster over two days. The first visit was on 17 January 2017 and was unannounced. We returned to complete the inspection on 18 January 2017.

St Anne's Community Services- Doncaster provides personal care for adults with a learning disability in a supported living setting. The service is delivered in 23 shared or self-contained community based properties in Doncaster. The service is divided into five separate geographical teams. Each geographical area has either, a registered manager or a manager who has begun the process of registration with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was previously inspected in May 2016 and we identified the service was not meeting six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in respect of notifying us of incidents, involving people in planning their care, gaining consent, meeting people's needs and preferences, planning for risks and keeping people safe, and keeping appropriate records.

Following the inspection, the provider sent us an action plan, which detailed how improvements would be made. During this inspection, we saw the provider had made considerable progress in relation to the action plan to address previous areas of concern. Whilst improvements had been made we will check at our next inspection to determine if the improvements have been sustained and embedded into everyday practice.

There were enough staff with the right skills and knowledge to support people. Staffing was sufficient and flexible to meet people's needs and staff had time to respond to people's needs in an unrushed way. People were given the time to communicate at a pace that suited them. Staff had good support and supervision to fulfil their role effectively and felt confident in approaching the registered manager if they needed extra guidance. People were protected by the service using safe and robust recruitment processes.

Staff understood that although they had a duty of care to help keep people safe, people were also free to make their own choices even if this could increase the level of risk to that person. The risk of harm to people was reduced as robust risk assessments had been implemented. Staff were trained in safeguarding and understood the processes for reporting abuse or suspected abuse.

Staff assessed people's nutritional needs and supported them to have a balanced diet. Staff supported people to access the healthcare services they required and monitored their healthcare appointments.

People and their relatives, where appropriate, were involved in the assessment, planning and review of their care. Staff considered people's choices, health and social care needs, and their general wellbeing.

Staff supported people in a way which was kind, respectful and encouraged them to maintain their independence. Staff also protected people's privacy and dignity.

People received their medicines on time and according to their preferences, from staff with the necessary training and who had their competence assessed. There were systems in place for the storage, administration and disposal of medicines. The improvements in recording and auditing of medicines needed to be continued and sustained.

People had opportunity to participate in a wide choice of activities. People were involved in a range of activities on the day we visited. People were able to attend day centres if they so wished. There were several community based activities which people enjoyed, such as, dog walking for a local greyhound rescue centre.

People we spoke with said if they had any concerns or complaints they would feel confident discussing these with staff members or management. They were sure the correct action would be taken if they made a complaint.

Whilst we found some need for further improvement, care plans had improved from our previous inspection. People's care files were written in an easy read format which included pictures to help people understand its content. Documents gave a good level of detailed guidance to inform staff of how to deliver person specific care. The improvements in care plans and recording needed to be continued and sustained.

There were quality assurance processes in place to enable the registered manager to have oversight of the home and to ensure that people were receiving the quality of service they had a right to expect. The improvements in auditing needed to be continued and sustained.

## 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 safe but we need to see the improvements made have been sustained.

There were enough staff to meet most people's needs effectively.

Risks to people's safety were adequately identified and addressed.

People's medicines were safely managed.

Safe recruitment practices were in place.

### Is the service effective?

**Good** ●

The service was effective.

The service supported all staff through training, supervision and annual appraisal in line with the provider's policy.

Staff assessed people's nutritional needs and supported them to have a balanced diet.

The registered manager and staff knew the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff supported people to access the healthcare services they needed.

### Is the service caring?

**Good** ●

The service was caring.

People were treated with respect and dignity.

Staff spoke to people in a kind, patient and engaging way.

People were able to express their views and be actively involved in making decisions about their care, treatment and support.

### Is the service responsive?

**Good** ●

The service was not always responsive.

Care records were up to date to ensure people's care needs were accurate.

A range of social activities were provided.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments.

**Is the service well-led?**

The service was well led but we need to see the improvements made have been sustained.

Action had been taken to address and maintain improvement in relation to the previous identified breaches in regulation.

There were a range of audits to monitor and assess the quality of the service, although these did not always identify issues.

People, relatives and staff had confidence in the management and leadership of the service.

**Requires Improvement** 

# St Anne's Community Services- Doncaster

## **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 17 and 18 January 2017 and was unannounced. The service was inspected by two adult social care inspectors.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we looked at all the information we held about the service. This information included the statutory notifications that the service sent to the Care Quality Commission. A notification is information about important events that the service is required to send us by law.

We spoke with three people who used the service, five staff, and a registered manager and a temporary manager. We observed the care provided to help us understand the experience of people who could not talk with us. We looked at seven people's care records and four staff records. We also looked at records related to the management of the service such as details about the administration of medicines, complaints, accidents and incidents, safeguarding, Deprivation of Liberty Safeguards authorisations, health and safety, and quality audits.

# Is the service safe?

## Our findings

When we inspected in May 2016, the provider had not ensured people always received their medicines as prescribed. The provider sent us an action plan, detailing how they would address the shortfalls.

At this inspection we found that medicines management had improved. Staff supported people to take their medicines safely. The provider trained and assessed the competency of staff responsible for the administration of people's medicines. People's Medicines Administration Records (MAR) were predominantly up to date and accurate. They showed that people had received their medicines as prescribed although, not all remaining medicine stocks were reflective of the information recorded. For example, one person's MAR showed that 100 paracetamol had been received, two tablets administered, yet there were 110 tablets in stock.

The service had up to date PRN (when required) medicines protocols. These advised staff when and under what circumstances individuals should receive or be offered their PRN medicine. Staff had a clear understanding of these protocols. Medicines were stored securely and safely. For example, staff monitored fridge and room temperatures. Staff carried out medicine checks for each shift handover to ensure people received their medicines safely. The registered manager conducted monthly medicine management audits and analysed the findings from the audits and shared any learning outcomes with staff to ensure people received their medicines safely.

We also found that improvements had been made with regard to risk assessments in people's care plans to check that they protected from harm. People's individual risks were identified and risk assessment reviews were carried out to keep people safe. For example, risk assessments for behaviour management, eating and drinking and accessing the local community.

People told us they felt safe in the service. Comments included: "I like it here, I know I'm safe." And, "I would speak to staff if I was worried about anything, they would help me."

The service had a policy and procedure for safeguarding adults from abuse. Staff understood the types of abuse, and the signs to look for. Staff knew what to do if they suspected abuse had occurred. This included reporting their concerns to the registered manager, the local authority safeguarding team, and the Care Quality Commission (CQC). Staff we spoke with told us, and records confirmed that they had completed safeguarding training. One staff member said, "I would report anything without hesitation." Another member of staff said, "If I identified any abuse I would report it to the manager immediately." Staff were aware of the provider's whistle-blowing procedure and said they would use it if they needed to.

The service had enough staff to support people safely and in a timely manner. The registered manager carried out a dependency assessment to identify staffing levels required to meet the needs of people using the service. The staff rota showed that staffing levels were consistently maintained to meet the assessed needs of people and that staffing levels increased in line with changes in people's needs where required. However, the managing continence section of one care plan stated that the person was incontinent if left in

bed so staff should get her up at 06.30. Another section of the care plan stated, "We have been advised not to get the person up at 6 as we only have 1 staff member. Daily notes for showed that on four occasions, the person was checked at 06.00 am, dry, left until 08.00 then was found to have been incontinent. This showed a negative impact on the person due to staffing. We discussed this with the registered manager who assured us this would be remedied immediately.

People were protected against the risks of receiving support from unsuitable staff. Potential staff were interviewed by a management and client recruitment panel. Recruitment checks undertaken ensured staff selected had suitable qualities and experience to support people safely. Checks had been undertaken with regard to criminal records, proof of identity, previous conduct in employment and character references. Current photographs were in place and information about people's employment histories and reasons for leaving previous care roles were checked, information was also gathered about people's medical fitness to undertake the role.

Whilst improvements had been made we will check at our next inspection to determine if the improvements have been sustained and embedded into everyday practice.



# Is the service effective?

## Our findings

At our last comprehensive inspection in May 2016 we found when people did not have the capacity to consent, the provider had not always acted fully in accordance with legal requirements.

We had asked the provider for an action plan to address the breaches identified. The provider sent us an action plan telling us how they would address this issue and when they would complete the action needed to remedy the concern. At this inspection we checked to ensure the action plan had been completed and to see 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.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

All managers had attended DoLS/MCA training in response to the May 2016 inspection and as such knew the conditions under which an application may be required to deprive a person of their liberty in their best interests under DoLS. Meeting minutes show that MCA is a regularly discussed topic.

In most cases staff asked for people's consent, when they had the capacity to consent to their care. Care records clearly evidenced people's choices and preferences about their care provision. Staff we spoke with understood the importance of gaining people's consent before they supported them. For example, staff sought consent, prior to giving personal care. However, one care plan contained a best interest document, which would have benefitted from being reviewed. This was about the use of a car seatbelt clip. The registered manager accepted that this had been missed during the most recent audit and would be remedied immediately.

People were cared for by staff with the relevant skills and experience to meet their needs. People told us that they felt staff were competent and well trained. When asked what they thought about the staff, one person told us, "I think staff are really good."

The registered manager had a commitment to staff learning and development. New staff were supported to learn about the provider's policies and procedures as well as people's needs. An induction was completed to ensure that all new staff received a consistent and thorough induction. Staff had undertaken induction workbooks and the manager was aware of the introduction of the care certificate and explained that new staff would be working towards this. The care certificate is a set of standards that social care and health

workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. Staff told us that they valued the induction. One staff member said, "I shadowed existing staff which enabled me to become familiar with people's needs." Another member of staff said, "The induction process was thorough and gave me all the tools I needed to start with confidence."

Staff received support to understand their roles and responsibilities through face to face discussion and talks with the registered manager or senior staff member. Observations of practice formed part of the supervision process. Team meetings included an agenda item of 'regulation of the month' and we saw that one location had a CQC board to keep staff up to date with requirements. Staff said that they took opportunities within these forums to raise issues, and they could approach the registered manager at other times who they found very supportive. Staff had their competency assessed in areas such as personal care, infection control, food hygiene and medicines.

We received positive comments from people with regard to food. One person told us, "I like the food, it's lovely." Whilst another person said, "It's delicious." People were able to choose what they had to eat and drink. There were regular meetings where people were asked what they would like to eat that week. People were given choices of main meal and could choose alternatives if they wished. There were no set mealtimes and people could choose when and where they had their meals. Independent living skills were promoted and observations showed people freely using the kitchen to make drinks whenever they were thirsty. People were also encouraged to be involved in purchasing shopping and preparing the meals.

Staff supported people to access healthcare services. We saw the contact details of external healthcare professionals, such as the GP, dentist and district nurses in people's care records. Staff completed health action plans for everyone who used the service and monitored their healthcare appointments. Staff completed hospital passports for every person who used the service, which outlined their health needs for healthcare professionals to know when they attended the hospital. During the inspection we saw one person was being visited and assessed by a speech and language therapist. Speech and language therapists work closely with people who have various levels of speech, language and communication problems, and with those who have swallowing, drinking or eating difficulties.

## Is the service caring?

### Our findings

The staff we spoke with clearly demonstrated they had a good knowledge of people's individual needs and could describe what they liked, disliked and how they preferred to be supported. Staff were also knowledgeable about people's interests; their previous life history and family dynamics. One member of staff told us, "The more I know and understand about a person the better relationship I can develop."

People were cared for by kind, compassionate and caring staff. People were complimentary about the caring nature of the staff and the management team. One person said of staff, "I like them all. They are nice." Another person told us, "I like living here, I am well looked after."

People responded well to staff and staff appeared to know people very well. There was a relaxed, atmosphere in all areas of the service we visited. People enjoyed the interaction they had with staff, there was lots of laughter and people appeared to be very happy. One person said, "I am happy because staff care. They are giving me a birthday party and a singer." We also noted that the provider had coffee, questions and cakes (CQC) mornings to promote involvement and awareness of the expectations of the regulator.

Staff respected people's choices and preferences. For example where people preferred to spend time in their own rooms, or in the lounge, we observed this happening. We saw that staff regularly checked on people's wellbeing and comfort.

Staff respected people's privacy and dignity. We saw staff knocked and waited for a response before entering people's rooms, and they kept people's information confidential. Staff told us people's bedroom doors were closed when they delivered personal care. People were well presented and we saw how staff helped people to adjust their clothing to maintain their dignity. Records showed staff received training in maintaining people's privacy and dignity. ☐ The provider had dignity champions and staff described that both staff and clients were registered as champions.

People were encouraged to continue to have relationships with their relatives and friends. People told us that they had enjoyed seeing friends at parties and clubs that they attended. A comment, within a recent relative survey stated, "My daughter receives excellent personalised support that is responsive to her choices and needs. The quality of her support has improved dramatically this year."

People's care was person centred. People described how the care they received met their individual needs. One person told us "The staff are very nice, they are always there when I need them."

# Is the service responsive?

## Our findings

People received personalised care and support specific to their needs, preferences and diversity. Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved.

At our inspection in May 2016 we found care records lacked detail. This inspection found improvements had been made and the service was now meeting the legal requirement. Care records gave information about people's health and social care needs. They were personalised and reflected the service's values that people should be at the centre of planning their care and support.

Staff carried out a pre-admission assessment of each person to see if the service was suitable to meet their assessed needs. Where appropriate staff involved relatives in this assessment. Staff used this information as a basis for developing tailored care plans to meet each person's needs. These contained information about their personal life and social history, their physical and mental health needs, allergies, family and friends, preferred activities and contact details of health and social care professionals.

People's care files were written in an easy read format which included pictures to help people understand its content. Documents gave a good level of detailed guidance to inform staff of how to deliver person specific care. Information included a one page profile which highlighted important parts of the person's life, information about what a good day and bad day looked like for the person, preferred routines and preferences, risk assessments, communication information, life histories, behavioural guidelines, and goals and aspirations. People's religious preferences had been highlighted within the care plan and people were supported to practice their religion if they wished. People had health action plans with specific information about their health needs and appointments they had attended. This meant staff had clear guidance to follow to support people with their individual needs in a personalised way. Staff completed daily reports about each person so information about the person's day could be handed over to other staff appropriately. People were encouraged to be involved in their care plan and agreeing to its content.

We saw a 'read and sign' document signed by staff for each support plan completed. This showed staff had a good understanding of the support people required.

People were not at risk of social isolation. People and staff confirmed that people were supported to choose what hobbies, interests and activities they wanted to partake in. We saw written and photographic evidence of community involvement, for example, some people volunteered to walk dogs from a local greyhound rescue shelter. People told us that they also attended music concerts, pantomimes and parties. One person told us, "We had a Christmas party, it was good. We also saw that some people had been involved in a cake baking activity. The cakes were then given to people who were raising awareness of homelessness by camping out.

The registered manager and staff explained that for some people, new experiences needed to be introduced slowly and gradually so people were accepting of the change and were therefore more likely to enjoy and

embrace it. From the information we saw in people's care plans it was clear that staff supported people's preferences, including diverse expressions of sexuality, in a very supportive and sensitive way.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments. People were made aware of the complaints system and an easy read version was available. The complaints procedure set out the process which would be followed by the provider and included contact details of the provider and the Care Quality Commission. This ensured people were given enough information if they felt they needed to raise a concern or complaint. Where complaints had been made, there was evidence of them being dealt with in line with the complaints procedure and of them being resolved to people's satisfaction.

## Is the service well-led?

### Our findings

The service was divided into five geographical areas, each of which had a manager. Two of the managers had recently been registered with CQC and the remainder had begun the registration process. After the last inspection, we were informed that the management team had a clear plan for further changes and improvements to improve the quality of service people received. We found at this inspection that improvements had been made. We will check at our next inspection to determine if the improvements have been sustained and embedded into everyday practice.

Staff were positive about the culture of the team. All of the staff we spoke with were confident that any poor practice would be dealt with immediately. Staff members said morale was good within the staff team. Staff told us that if they were encouraged to offer opinion and comment about the service. One member of staff said, "We are all free to make suggestions to improve the service, there is a culture that allows us to do that." Staff also said communication was good within the team. We saw formal handovers were in place each day to help ensure people received consistent care. Staff told us, "We are a very tight knit team that work with and for each other to deliver the best possible service we can."

Peoples feedback was sought regularly. This was through daily, informal, conversations and regular more formal meetings and surveys. During the service user meetings people discussed their experience of the service in line with the five CQC domains.

Relatives and healthcare professionals also completed feedback surveys about the service. We looked at the completed survey forms. The areas covered in these surveys included individual needs and choices, healthcare support, activities, equality and diversity, complaints, the environment, and staffing. All the responses were positive. One relative said, "I am very happy with the care given."

There was evidence that learning from incidents and accidents and investigations took place and appropriate changes were implemented. For example, additional staff training had been provided in medication, following a medication error. Actions had been taken in line with the service's policies and procedures. Regardless of the location, where incidents had taken place and an action plan put in place, all managers signed to show awareness. This demonstrated oversight of the whole service and not just part thereof.

Regular audits were made of all aspects of people's care and treatment including risk assessments, care plans, health action plans, maintenance, care reviews, supervision and training. These improved systems and audits were in place to oversee the quality of the service, although these audits had not recognised the issues we identified regarding care plans and medication.

We saw that managers meetings took place monthly. These meetings looked at business development, new or amended policies, training, health and safety and service user needs. Each meeting re-visited both the overall action plans developed from the quality audit and the action plan devised following the inspection in May 2016.

