St Anne's Community Services

St Anne's Community Services - Phoenix Court

Inspection report

16-18 Phoenix Court
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22 November 2023
30 November 2023
05 December 2023
12 December 2023

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Phoenix Court is a residential care home providing personal care for up to 7 people with a learning disability and autistic people. At the time of our inspection there were 5 people using the service.

People's experience of the service and what we found:
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessment and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
Risks to people were not always identified, assessed or mitigated. Medicines were not always managed safely. Staffing arrangements need to be reviewed as although there were enough staff to keep people safe, additional duties impacted on the level of support staff could provide. Thorough recruitment processes were not always implemented. Quality assurance processes were not robust as some issues we found at inspection had not been identified or addressed. However, the provider acted promptly in taking action to address the issues and made improvements during the inspection. 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.

Right Care:
People were comfortable and relaxed around each other and in the company of staff. Staff knew people well and had developed positive relationships with individuals. The management team were in the process of updating support and care documentation. Some records contained person-centred information, but others lacked detail and did not accurately reflect people's needs. Systems were in place to safeguard people from abuse.

Right Culture:
People were supported with social activities and accessing the community. Staff involved and encouraged people with daily living activities such as preparing and serving meals. People were supported to keep in touch with relatives and friends who could visit at any time.

A new manager started in post on the first day of the inspection. Apart from the manager, no senior staff were employed which meant staff roles were not clear in terms of who took responsibility and was in charge when the manager was off. The provider had an action plan in place to make improvements to the service and was working with external stakeholders to implement the changes.

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

Rating at last inspection
The last rating for this service was good, published on 9 December 2020. There were no breaches of regulations, however, we made a recommendation in relation to medicines.

Why we inspected
This inspection was prompted by a review of the information we held about this service. 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.

You can read the report from our last comprehensive inspection by selecting the 'All inspection reports and timeline' link for St Annes Community Services – Phoenix Court on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to regulations 12 and 17.

Please see the action we have told the provider to take at the end of this report.

Follow Up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

St Anne's Community Services - Phoenix Court

Detailed findings

Background to this inspection

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

Inspection team
The inspection team consisted of an inspector, a medicines inspector, a regulatory co-ordinator 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.

Service and service type
Phoenix Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Phoenix Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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

Notice of inspection

The inspection was unannounced. Inspection activity started on 22 November 2023 and ended on 12 December 2023. We visited the service on 22 and 30 November and 5 December 2023.

What we did before the inspection
We reviewed information we had received about the service since the provider registered. We sought feedback from the local authority quality and safeguarding teams who work with the service. We used the information the provider sent us in the provider information return (PIR). 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 this information to plan our inspection.

During the inspection
We spent time with people in the communal areas observing the care and support provided by staff. We spoke with 5 people who used the service and 3 relatives about their experience of the care provided. We spoke with 9 staff including the manager, peripatetic manager, area manager and support staff.

We reviewed a range of records. This included 4 people's care records and 5 people's medicine records. We looked at 3 staff recruitment files. A variety of records relating to the management of the service were reviewed.

We provided feedback to the manager and peripatetic manager when we visited on site on 5 December 2023 and at the end of the inspection.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

At our last inspection we recommended the provider considered current guidance on safe storage, and recording opening dates, of topical medicines. The provider had made some improvements, however we found other shortfalls relating to medicines.

People were supported to receive their medicines in a way that was not always safe. Topical medicines charts were not always completed correctly. There were no patch application records to show where on the body medicine patches had been applied. This meant we could not be sure patches were being rotated in accordance with manufacturer's guidelines. Care plans for people requiring monitoring of bowel habits were not always being followed correctly so we could not be sure people were having their medicines administered safely. Covert administration and the policy surrounding this need to be reviewed. If covert administration is being used or medicines are being put into food or drink, a pharmacist needs to consulted to make sure no interactions between the food/drink and medicines occur.

Medicines were not always managed safely. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely in a clean environment. Regular audits were completed and actions from the audits were currently being addressed.

Assessing risk, safety monitoring and management
The provider did not always assess risks to ensure people were safe. Staff did not always take action to mitigate any identified risks. Risks were not always identified or acted upon by the provider or staff. Areas of the home were cold as the heating system had not been monitored or adjusted to ensure people were kept warm. One person's pressure relieving mattress had been set incorrectly placing the person at risk of pressure damage. There was no guidance for staff about the correct setting or records to show the mattress had been checked. Sensory equipment used by another person was damaged posing a risk to their health. An agency staff member on their first shift received no induction or handover and was left alone to support a person they did not know. The provider took action to address these concerns when we raised them.

Learning lessons when things go wrong
The provider did not always learn lessons when things had gone wrong. Lessons learned from incidents were not always acted on. For example, 1 person's care records showed twice nightly safety checks were

required on equipment they used. There was no evidence to show these checks had been carried out.

We found no evidence people had been harmed, however, risks to people were not always assessed and managed placing them at risk of harm. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was responsive to the inspection findings and provided assurance they had taken steps to address these shortfalls.

Staffing and recruitment
There were enough staff to keep people safe, but staffing arrangements impacted on people's quality of life. Staff who provided support to people also did all the cooking, cleaning, laundry and provided 8 hours 1-1 support daily for 1 person. No additional staff were employed to assist the support staff, although an extra staff member came in one night a week to take 2 people out. Staff comments included; "Cleaning tasks take us away from the time we have to spend with people" and "There's not always a driver on the late shift so we can't take people out." The peripatetic manager confirmed there was no system in place to calculate safe staffing levels. They said the provider was looking to implement a process.

Recruitment processes were not robust. Gaps in employment history had not been explored with 1 applicant and their interview notes were dated after their start date. There was only 1 reference each for 2 applicants and this was not from their last employer.

The provider did not have effective systems in place to ensure staffing levels met people's needs and there were gaps in recruitment processes. This was a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
People were protected from the risk of infection as staff were following safe infection prevention and control practices. Staff wore PPE appropriately and followed hand hygiene practices. The home looked clean and cleaning schedules were in place. However, cleaning records had not been completed by staff on several days. This had been picked up by the provider and addressed with staff.

Visiting in Care Homes
People were able to receive visitors without restrictions in line with best practice guidance. People were supported to keep in touch and meet up with friends and relatives. Relatives said they were able to visit at any time.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

The provider was working in line with the Mental Capacity Act. The service had legal authorisations in place to deprive a person of their liberty, as appropriate. Some best interest decisions had been completed where people lacked capacity to make their own decisions such as the use of monitoring equipment. However,

there was a restriction in place which had not followed this process. The provider took action to address this when we raised it.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
People were safeguarded from abuse and avoidable harm. Staff had received safeguarding training and understood the procedures to follow if abuse was found or suspected. Records showed allegations of abuse were reported, investigated, and acted on. Relatives said they felt their family members were safe in the home.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
The provider did not have a fully supported management structure. The provider's system did not always effectively monitor the quality of care provided to drive improvements. Senior managers were supporting the new manager during their induction period. However, there was no deputy manager or seniors employed in the home, only support workers. This meant when the manager was off, staff were not clear who was in charge or leading the shift. The new manager was reviewing allocation and shift patterns and had introduced written handovers to improve communication. Quality assurance processes had identified some of the issues we found at the inspection. The provider had implemented an improvement plan following a local authority quality monitoring visit in July 2023. However, provider audits showed progress with improvements has been slow.

The provider had not consistently created a learning culture at the service which meant people's care did not always improve. Care and support records were not always accurate, up to date or fully reflective of people's needs. For example, one person's support plan contained limited information about a specific mental health condition. Staff knew people's specialist dietary requirements, however, food records did not always show correct food textures had been provided. People's financial records did not refer to weekly payments made to use the home's minibus and it was not clear how these agreements had been reached. Financial records were not always kept securely and there were not always 2 staff signatures recorded for transactions.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team were responsive to the inspection findings and provided assurance they were taking steps to improve.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
The provider had systems to provide person-centred care that achieved good outcomes for people. We received positive feedback from relatives about the staff. One relative said, "[Family member] is a changed person and has come on in leaps and bounds since coming here. We don't need to worry about [person] as they have everything they need." Staff knew people well and were kind and considerate in their interactions.

People were supported to follow their interests, hobbies and daily living activities. One person told us they liked having their nails done, baking and helping out in the kitchen. We saw staff spent time painting this person's nails and the person showed us the homemade soup and bread they had made for lunch. People were involved in preparing and serving meals and went out into the community on group trips and individually. The new manager and staff were working with people to look at new experiences and activities to further enhance their quality of life.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
The provider understood their responsibilities under the duty of candour. The manager provided assurance they were open and transparent when things went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
People and staff were not always involved in the running of the service and their protected characteristics were not always well understood. There were no meetings for people who lived in the home. Some relatives did not know a new manager had started. The provider's action plan identified improvements to be made in collecting and capturing people's feedback about their daily lives and support, which will be done individually through monthly reviews. Three relatives had completed satisfaction surveys in September 2023 and gave positive feedback about the care. One comment stated, "I am happy when I visit. Staff are upfront and there are no hidden agendas. They do seem to genuinely care for [family member]. "

Working in partnership with others
The provider worked in partnership with others. Staff supported people to access specialist support when required, including annual health checks. Care records showed the involvement of health and social care professionals such as GPs, occupational therapists and physiotherapists.

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 Risks to people were not assessed, mitigated or monitored. Medicines were not managed safely. Regulation 12 (2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and mitigate risks to people or to improve the quality of the service. Regulation 17 (1)(2)(a)(b)