St Anne's Community Services

St Anne's Community Services - Smithies Moor Lane

Inspection report

46 Smithies Moor Lane
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
St Anne's Community Services - Smithies Moor Lane. Is a residential care home providing accommodation, and personal and nursing care to up to 6 people. The service provides support to 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 Care:
The service did not have effective systems to show care was person-centred care. People did not have plans to set out their day or week and there was no record to show how people's days should unfold, which meant staff decided what people should do. People did not have assessments and plans to ensure they were offered opportunities to achieve goals, learning, and new experiences.

People were not supported to follow their interests or take part in activities that were relevant to them. People did not have regular contact with the community and activities within the home were limited.

There were sufficient numbers of staff to keep people safe but the provider did not have effective systems for ensuring they had the enough staff to deliver high quality care. Care staff were observed cleaning the home and cooking meals so had less time directly supporting people.

We observed many positive interactions between staff and people who used the service. Staff knew people well and were kind and caring. For example, we saw staff supporting people to eat with care and dignity. People's support plans guided staff around how to deliver individual care tasks such as eating, continence and mobility in a person-centred way.

The service worked effectively with external stakeholders and other professionals.

Right Support:
The service did not manage several areas of risk and quality well. For example, the service had a minibus which was funded by 4 people. However, the minibus was used infrequently. The provider was aware of the issue but had not addressed this. CQC shared these concerns with the local safeguarding authority.

People were not supported to receive their medicines in a safe way and risks to people were not always well managed.

People were usually 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 usually supported this practice.

Right Culture:
The service had an action plan but this did not identify shortfalls that we highlighted at the inspection, which meant actions to drive improvement were absent. Many issues were not included such as the lack of community access, unsafe management of medicines, failure to assess some risks to individuals, inconsistencies in incident recording and reporting, and failure to monitor decision making processes.

Feedback about the registered manager was positive. Relatives and staff shared examples where they felt improvements had been made, such as communication and views. Staff felt well supported in their role.

The management team were responsive to the inspection findings and shared information to show they were making improvements. However, we did not receive complete assurance from the provider that the issues relating to the minibus would be fully addressed.

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 20 September 2018).

Why we inspected
We inspected due to the length of time since the last inspection.

We undertook a focused inspection to review the key questions of safe and well-led only.
During the inspection we found there was a concern with supporting people to follow interests and to take part in activities that are socially and culturally relevant to them so we widened the scope of the inspection to include the key question of responsive.

For those key question 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 reports' link for St Anne's Community Services - Smithies Moor Lane on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to management of medicines and risks to individuals, person-centred care and good governance at this inspection.

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

Follow Up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well-led findings below.

St Anne's Community Services - Smithies Moor Lane

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 2 inspectors, a regulatory co-ordinator, an Expert by Experience and a medicines specialist advisor. 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
St Anne's Community Services - Smithies Moor Lane 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. St Anne's Community Services - Smithies Moor Lane is a care home with 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 a registered manager in post.

Notice of inspection
The inspection was 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 Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England 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 in communal areas observing the care and support provided by staff to help us understand the experience of people who could not talk with us. We spoke with 4 relatives and 8 staff, including support workers, the registered manager and area manager.

We reviewed a range of records. This included 3 people's care records and 4 people's medicines records. We reviewed 2 staff recruitment files and a variety of records relating to the management of the service.

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 Good. At this inspection the rating has changed to 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
People were not supported to receive their medicines in a safe way. The service did not follow correct procedures when administering medicines which meant people did not always get their medicines as prescribed. Some medicines were prescribed to be administered regularly but were being given on an 'as required' basis. Some medicines were added to food to ease administration, but potential medicine and food interactions were not checked. Sometimes doses of medication were amended without any evidence of health professional input.

The provider failed to ensure the safe and proper management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team responded during the inspection and shared information to show they were introducing systems to improve how they managed medicines.

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. The management of risk when people were distressed or agitated was unreliable. Staff did not have appropriate guidance to understand how best to support one person and the service was not monitoring situations when the person was distressed. CQC shared these concerns with the local safeguarding authority.

The provider did not do all that was reasonably practicable to mitigate risks. This placed people at risk of harm. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team responded during the inspection and shared information to show they were introducing systems to improve how they managed incidents.

We saw many examples where individual risks to people were appropriately assessed and support plans included measures to help keep people safe. This included areas such as moving and handling, eating and drinking.

Learning lessons when things go wrong

The provider did not always learn lessons when things had gone wrong. The system for managing, recording, and reporting incidents and concerns was unreliable. For example, daily records showed on 1 day there were 3 incidents involving aggression towards staff but no incident forms were completed. There was no information to show the provider had taken action to prevent repeat events or learned lessons.

The provider did not operate systems effectively to monitor the quality and safety of the services provided. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service shared examples where they had carried out robust investigations and had shared lessons learned with the whole team.

Staffing and recruitment
There were sufficient numbers of staff to keep people safe but the provider did not have effective systems for ensuring they had the enough staff to deliver high quality care. None of the staff who were employed to work at the service could drive the home's minibus which meant people only went out occasionally. A relative said, "Outside activities have definitely dropped off. They don't seem to have enough staff to enable outside activities."

Care staff were responsible for cleaning the home, preparing and cooking all the meals so had less time directly supporting people. The provider did not have a system for reviewing staffing arrangements to ensure there were sufficient staff to provide people with a good quality of life.

The provider did not operate systems effectively to monitor the quality of the services provided. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider operated safe recruitment processes. Checks and interviews were carried out before staff started working at the service. Disclosure and Barring Service (DBS) checks were completed for all staff. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment and staffing decisions.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
People were safeguarded from abuse and avoidable harm. Staff had completed safeguarding training and understood their responsibility to report concerns. Where safeguarding incidents had occurred, referrals had been made to the local authority safeguarding team.

Preventing and controlling infection
People were protected from the risk of infection as staff were following safe infection prevention and control practices. The provider had systems for maintaining appropriate standards of cleanliness in the premises. Staff had checklists to makes sure all areas of the home were cleaned on a regular basis.

Visiting in Care Homes
People were able to receive visitors without restrictions in line with best practice guidance. The provider supported and enabled visits for people living at the home to maintain contact with their family.

Is consent to care and treatment always sought in line with legislation 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)

Where needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support
People were not always supported as individuals, or in line with their needs and preferences. People did not have assessments and plans to ensure they were offered opportunities to achieve goals, learning, and new experiences. People did not have plans to set out their day or week and there was no record to show how people's days should unfold. This meant there was nothing in place to show people's routines were person centred.

Care was not always planned and delivered in a way to meet people's needs. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team responded during the inspection and shared information to show they were introducing systems to improve how they planned care and support.

We saw many examples where support plans guided staff around how to deliver individual care tasks such as eating, continence and mobility to people in a person-centred way.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
People were not supported to follow their interests or take part in activities that were relevant to them. People did not have regular contact with the community. One person had only been out of the service once in the last 3 months and this was to visit the dentist. Their care records stated they should have opportunities to go out.

Activities within the home were offered on both days of the inspection. However, we were not assured these were 'typical' days because activity records had big gaps and showed multiple entries where staff recorded 'listening to music' as an activity for the day. The service organised external people to lead activity sessions in the home, once a week. However, the session we observed was not tailored to the needs of the people who used the service. Staff and management told us activities and community access were areas that could improve.

Care was not planned and delivered in a way to meet people's needs. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

The provider was further developing their systems and processes to meet the Accessible Information Standard and to ensure people's communication needs were understood and supported. People had support plans which provided some basic information about their communication needs. The registered manager had recently purchased some pictorial aids with a view to reintroducing a communication system to support people to communicate using pictures.

Improving care quality in response to complaints or concerns
People's concerns and complaints were listened to, responded to and used to improve the quality of care. Staff and relatives felt confident that if they complained their concerns would be investigated thoroughly and dealt with in an open and transparent way. A family member told us they were, "Always listened to and staff did their very best to help and respect their wishes." Another family member told us they had discussed a health concern about their relative and the registered manager who had promptly contacted the appropriate health professional."

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 the rating has changed to Inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
The provider did not have a system to provide person-centred care that achieved good outcomes for people. The delivery of high-quality care was not assured by the governance in place. The importance of monitoring people's quality of life was overlooked. We found widespread shortfalls in systems that should be in place to make sure people's care was appropriate. For example, people had limited opportunities to access the community and reporting of incidents was inconsistent.

The provider did not operate systems effectively to monitor the quality and safety of the services provided. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
The provider did not monitor the quality of care provided in order to drive improvements. Governance systems were not reliable. The service did not manage several areas of risk and quality well. For example, decisions taken in relation to people who used the service were not operated effectively. The service had a minibus which was funded by 4 people. However, the service did not have adequate drivers which meant the minibus was often not used. The provider was aware of the issue but had not addressed this. CQC shared these concerns with the local safeguarding authority.

The provider did not operate systems effectively to monitor the quality and safety of the services provided. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
The provider had not consistently created a learning culture at the service which meant people's care did not always improve. The service had an action plan but this did not identify shortfalls highlighted at the inspection, which meant actions to drive improvement were absent. Many issues were not included such as the lack of community access, unsafe management of medicines, failure to assess risk when one person was distressed and agitated, inconsistencies in incident recording and reporting, and failure to monitor decision making processes.

The provider did not operate systems effectively to monitor the quality and safety of the services provided. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had systems to manage some areas of the service well, such as the safety of the building.

During both site visits we observed many positive interactions between staff and people who used the service. Staff knew people well and were kind and caring. For example, we saw staff supporting people to eat with care and dignity.

Comments from relatives were mainly positive and included, "Staff go above and beyond what is expected of them", "They do care so much for the residents they look after", "[Name of registered manager] communicates well. I couldn't wish for a better manager" and "[Name of registered manager] and the team have been great. I can't praise them enough".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
People and staff were involved in the running of the service and fully understood and took into account people's protected characteristics. The registered manager was developing a culture which encouraged everyone to share views. Staff told us they felt listened to and were asked to put forward suggestions. One member of staff said, "[Name of registered manager] is doing a good job. We have meetings and talk about everything." Another member of staff said, "[Name of registered manager] has only been here recently and is managing well. At team meetings we discuss each client, any changes, what works, and ask are they happy."

Working in partnership with others
The provider worked in partnership with others. The management team and staff understood the importance and benefits of working with external stakeholders. Care records showed staff had contacted other professionals when they had concerns about people's health and welfare.

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 registered manager explained the process they followed whenever an accident or incident occurred which included being open and transparent. Relatives told us the service kept them informed and were confident the registered manager would share all relevant information.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not always planned and delivered in a way to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the safe and proper management of medicines. The provider did not do all that was reasonably practicable to mitigate risks.

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
Treatment of disease, disorder or injury	The provider did not operate systems effectively to monitor the quality and safety of the services provided.

The enforcement action we took:

Warning notice