St Anne's Community Services

St Anne's Community Services - York DCA

Inspection report

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Date of inspection visit:
26 October 2023
31 October 2023

Date of publication:
07 December 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
St Anne's Community Services – York DCA provides personal care to people living in their own homes and supported living settings. The service provides support to people with a learning disability and autistic people. At the time of the inspection, 35 people were using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of the inspection, 4 people were receiving personal care.

People's experience of using this 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 assessments 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 safely assessed, monitored, and managed. There was insufficient guidance in place to support staff to keep people, themselves and others safe. People's medicines were not safely managed. Medicines were not always in stock and records were not always in place, or clear and up to date. Incidents and potential safeguarding concerns were not always dealt with appropriately. People were not always supported by staff who were safely recruited. People were not always well supported with their communication needs. We received positive feedback about the care and support provided from the domiciliary care agency side of the service.

The service did not have copies of relevant Mental Capacity Act (MCA) documentation and therefore we could not be assured that people were being supported in the least restrictive way possible and in their best interests. People were not supported to have maximum choice and control of their lives. Systems in the service did not support best practice in this area and we have made a recommendation about this.

Right Care:

There were not always enough staff to provide person-centred care within the supported living setting. Activities and outings were limited, and some staff told us this was due to staffing levels. Assessments of people's needs were not always up to date and did not always reflect the person as a whole. Support plans did not promote strategies to enhance people's independence and did not contain clear pathways to future goals and aspirations. People's sensory needs had not been explored fully. People's nutritional needs were not always clearly communicated to staff. People's social needs were not met, and people were not

provided with appropriate stimulation.

Right Culture:

The provider had not created a culture in which people were able to develop and flourish. Support delivered was not person-centred and did not empower people to lead their best lives and increase their independence. Quality assurance systems and processes were ineffective. Systems were not in place to support continual improvement of the service. Relatives told us they felt comfortable in raising concerns, and staff and relatives spoke positively about the registered manager. The provider responded to feedback and an action plan was in place.

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 2 July 2018).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding and record keeping. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only. Due to concerns identified on inspection, the scope of the inspection was expanded to include the key questions of effective and responsive.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Anne's Community Services – York DCA on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, person-centred care, staffing and good governance.

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

We have made a recommendation about ensuring compliance with the Mental Capacity Act (MCA).

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 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, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service responsive?

Inadequate

The service was not 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 - York DCA

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 was carried out by an inspector and a medicines specialist advisor.

Service and service type
The service operated a domiciliary care agency, providing personal care to people living in their own houses.

The service also operated a supported living setting, providing support to people in their home so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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
We gave the service short notice of our visit to the office. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

We gave several days' notice of our visit to the supported living setting because some of the people using it could not consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

Inspection activity started on 26 October 2023 and ended on 8 November 2023. We visited the location's office on 26 October 2023 and the supported living setting on 31 October 2023.

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 (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 information gathered as part of monitoring activity that took place on 13 September 2023 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with 3 relatives about their experience of the care provided. We spent time with and observed 1 person who used the service. We spoke with 11 members of staff including the registered manager, deputy manager, area manager, and 8 care workers. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 2 people's care records and medicine records. We reviewed a variety of documents relating to the management of the service, including policies and procedures, staff recruitment records, training and quality assurance documentation.

On 2 November 2023 we served a letter under Regulation 17(3) of the Health and Social Care Act (Regulated Activities) Regulations 2014, requesting a detailed improvement plan, addressing the high risk areas we identified on inspection. The provider submitted an action plan on 3 November 2023.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to people were not safely assessed, monitored, and managed. There was insufficient information in people's support plans around potentially life-threatening conditions, and staff were not always clear what actions needed to be taken to keep people safe.
- Where people communicated with behaviours which may challenge others, there was insufficient guidance in place to enable staff to support people safely and effectively. One person had a Positive Behaviour Support (PBS) plan in place which was out of date. One person's support plan referred to a PBS plan and de-escalation protocol, however, these documents were not in place. Due to the lack of guidance, there was a lack of a consistent approach, which potentially impacted negatively upon people's behaviours and routines.
- There was insufficient guidance and measures in place to support staff to keep themselves and others safe. Staff had not received lone worker training. The provider confirmed technology was being introduced to support staff safety when lone working.
- The environment of the supported living setting was not safe. Cleaning chemicals and medicines were stored in locked cupboards. However, the keys were in the locks or near the locks, meaning chemicals and medicines were potentially accessible to all.
- Radiators did not have protective covers on them. The service supported people with visual impairments, who used touch to navigate around the service. This placed them at risk of a burn injury.
- The supported living setting's fire risk assessment was out of date and recommendations in the assessment had not been completed. Staff had not taken part in regular fire drills.

The provider failed to assess, monitor, and manage risk. 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 provider confirmed all support plans would be reviewed. Further, the provider's PBS team would prioritise St Anne's Community Services – York DCA to review people's needs in the supported living setting.

Using medicines safely

- Medicines were not managed safely.
- Prescription medicines for people were not always in stock and no action had been taken by staff to rectify this.
- Where people were prescribed medicines on a 'when required' basis or with a variable dose, protocols were not always clear, robust or in place. Staff did not record why these medicines were given and if they were effective.

● Unsafe amounts of medicine stock were held in the service. There was no clear explanation as to why large amounts of stock were held and we therefore could not be assured people received their medicines as prescribed. The service held out of date stock and had not disposed of this appropriately.
● Medicine administration records were not always accurate or up to date. They did not always reflect people's current prescription medicines. Medicine records and records for the application of creams did not match, and it was therefore not possible to identify which staff member had applied people's creams, as there were 2 different staff signatures on several occasions.

The provider failed to manage medicines safely. 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.

Systems and processes to safeguard people from the risk of abuse; learning lessons when things go wrong
● Incidents and potential safeguarding concerns had not always been dealt with appropriately. Issues were not always escalated in a timely manner.
● Staff did not always recognise actions that were inappropriate. We found 1 occasion where staff failed to seek medical attention or take appropriate action following an incident.
● There was limited analysis of incidents. Whilst reports were submitted to the management team to review, there was no evidence of trends and triggers being identified. Incidents were not always investigated robustly; rather, assumptions were made as to what may have happened. This did not support learning or the improvement of the quality of care provided.

The provider failed to have robust safeguarding procedures in place. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had arranged for safeguarding training and were supporting staff in this area, to improve their knowledge and the reporting procedures and processes.

Staffing and recruitment
● Staff were not always safely recruited. We reviewed 3 staff recruitment files. 2 staff members were safely recruited. However, 1 staff member did not have a 'right to work' check in place. This staff member was taken off the rota until this was obtained.

The provider failed to have robust recruitment procedures in place. This was a breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were not always enough staff to provide person-centred care. One person required 2:1 support in the community. Activities and outings for this person were limited and staff told us they often did not have the staff to support this person outside the house. When there were enough staff, some were not able to drive and so were not able to support them into the community.
● One person had enjoyed swimming before the COVID-19 pandemic. This person had not been swimming since the pandemic as additional staff were needed to learn this person's routine and support them at the swimming pool.

The provider failed to have sufficient staff to provide person-centred care. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Positive feedback was received about staffing levels for the domiciliary care agency side of the service. There had been no missed calls and a relative told us "[Person] is supported by consistent support workers

who are kind and caring and go above and beyond."

Preventing and controlling infection

● Laundry systems in the supported living setting did not support good infection control. The washing machine was located in the kitchen and soiled linen was carried into the kitchen without being bagged. This created a risk of cross contamination.

The provider failed to have safe laundry systems in place. 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 supported living setting was clean and tidy. There was a cleaning schedule in place which included deep cleaning. A relative told us, "They are always cleaning."

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Assessments of people's needs were not always up to date and did not always reflect the person as a whole.
- Support plans did not promote strategies to enhance people's independence and did not demonstrate evidence of planning or consideration of the longer-term aspirations of each person.
- Support plans did not contain clear pathways to future goals and aspirations, and skills teaching was not included in people's support plans.
- People's sensory needs had not been explored fully, and there was limited sensory stimulation provided in the supported living setting. There were limited sensory-rich activities provided for people.

The provider failed to assess and meet people's full range of needs. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- The provider did not provide staff with the appropriate and relevant guidance and information to enable them to support people in a safe and person-centred way. Staff did not always recognise poor practice and the provider did not have systems in place to identify this.

The provider failed to provide staff with the knowledge and information needed to effectively perform their roles. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- People's nutritional needs were not clearly communicated to staff. One person had a food group unnecessarily restricted, and staff were not clear as to why.
- One person was required to eat regularly and certain food groups to prevent a medical episode. There was insufficient information for staff around this person's needs.
- One person needed to avoid certain foods, but this information was not readily available for staff, and staff were not always aware of which food was to be avoided.

The provider failed to fully assess risks around nutrition and provide staff with clear and appropriate guidance. 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.

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 when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● We could not be assured the service was working within the principles of the MCA. People were deprived of their liberty, but the provider did not have copies of, and had not seen, the relevant legal authorisations. The registered manager told us appropriate authorisations were in place, but professionals had refused to provide this information to them.

We recommend the provider takes appropriate steps to satisfy themselves that appropriate legal authorisations are in place, in date, and any conditions are being complied with.

● Where people lacked the capacity to make a certain decision, relevant assessments and best interest decisions were in place. However, these assessments and decisions had not been reviewed for over 12 months.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support
● Staff had not always worked effectively with other agencies as some incidents had not been escalated in a timely way. We also found 1 example where medical advice had not been sought when a person was expressing pain.
● In most cases there was evidence of appropriate referrals and support provided to people to access health services. A relative told us, "Staff were brilliant with [person] when they went to hospital."

Inadequate

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 inadequate. This meant services were not planned or delivered in ways that met people's needs.

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; planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's social needs were not met, and people were not supported with appropriate stimulation. People were not consistently supported to enjoy hobbies and interests, or given opportunities to try new things. People were not engaged consistently throughout the day in activities.
- One person's support plan confirmed they enjoyed going on holiday and going on train rides. The person had not been supported with either activity for several years. This person was displaying behaviours during our inspection visit which indicated they were bored; their support plan confirmed this. The person was offered limited stimulation.
- One person's support plan stated they would benefit from an increase in a variety of social and leisure activities in the community; this would improve wellbeing. This support had not been provided. One relative told us "Taking [person] out more would be better, or even little things like getting involved with cooking."
- Most staff told us people were not getting out and about enough and stimulation had reduced. Multiple staff told us this had negatively impacted people's wellbeing. Staff comments included, "[Person] used to be doing things all day but not now. Yesterday they were in bed more than out. They are even fed in bed. There is no quality of life for [person]" and, "I think [person] is more distressed now; some staff don't interact with them, and [person] isn't getting out."
- The provider did not effectively monitor people's quality of life. There was no analysis of whether service users' support plans were having a positive impact and improving people's daily living. There was no commitment to achieving long term goals and aspirations.

The provider failed to meet people's social needs, offer appropriate stimulation, and create an environment where people were able to flourish. 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.

- People were not always well supported with their communication needs. The provider had identified one person would benefit from a communication approach know as 'intensive interaction'. This had first been

identified in 2017. This training need for staff was again highlighted in July 2022. At the time of the inspection, the provider had not sourced this training for staff.
● Some staff told us that other staff did not communicate well with people. One staff member told us, "Some of the staff don't interact with [person] and chat to them, so they don't develop a bond."

The provider failed to ensure staff had the skills to meet people's communication needs. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's support plans generally contained good information about how people might communicate through their body language and actions.

Improving care quality in response to complaints or concerns
● The registered manager told us no complaints had been received in the last 12 months. A policy was in place to manage complaints should any be received.
● Relatives told us they felt comfortable in raising concerns. One relative told us, "I have never complained but I can always email [the registered manager]."

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 good. At this inspection the rating has changed to 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had not created a culture in which people were able to develop and flourish. Support delivered was not person-centred and did not empower people to lead their best lives and increase their independence.
- Neither the provider nor the registered manager were alert to the culture within the service. The provider and registered manager had not been pro-active in identifying the shortfalls in care and putting in place the correct support for people.

The provider failed to create a person-centred and empowering culture. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff and relatives spoke positively about the registered manager, who was described as 'approachable', 'accessible', 'supportive' and 'top notch'.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care

- Quality assurance systems and processes were ineffective. Audits and oversight failed to identify most of the issues identified on inspection. Where issues had been identified, they had not been resolved in a timely manner.
- Systems were not in place to effectively identify, manage and monitor risk. Support plans and risk assessments were not always up to date and contained significant shortfalls. This meant staff did not have appropriate guidance to enable them to support people safely and effectively.
- Systems were not in place to support continual improvement of the service. The quality of the service had deteriorated since our last inspection.

The provider did not have systems In place to assess, monitor and Improve the quality and safety of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider did respond to our feedback and feedback from other professionals. An improvement plan was in place and actions identified on inspection were added to this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others; 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

● Relatives told us they were involved with people's care, but this was informally rather than with formal review meetings.

● Relatives provided mixed feedback about communication with the service. Comments included, "[Staff] are very good at ringing me up if they are concerned. But sometimes things get lost in communication or are not documented" and, "We weren't told about a change in medication; we only found out by accident."

● Staff had not always escalated concerns to the relevant people when things went wrong. However, learning had already taken place and the duty of candour was complied with for more recent incidents.

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
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to have robust safeguarding procedures in place. Regulation 13(1) - (4)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to have robust recruitment procedures in place. Regulation 19(1) - (3)