

Community Places Limited

Community Places

Inspection report

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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?

Requires Improvement 

Summary of findings

Overall summary

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.

About the service

Community Places provides care and support to people with a learning disability or autistic people. Community Places is home to 12 people. At the time of inspection 10 people live in the main building and 2 people live in the bungalow. The service can support up to 16 people.

People's experience of using this service and what we found

Right Support:

Not all risks were assessed to keep people safe and we asked the manager to complete risk assessments for window restrictors and a profiling bed with bed rails immediately after the inspection. There were enough staff available to support people with their daily routines and activities.

Right Care:

Medicines were not managed safely and there were errors in administration of medication, stock counts and MAR sheets. Infection prevention and control was not managed effectively. Staff had training on how to recognise and report abuse and how to protect people from poor care. The service worked well with other agencies to keep people safe.

Right Culture:

Staff did not always talk with people effectively to find out what activities they might want to do. Accident and Incident forms were not reviewed in a timely manner and common themes from these forms did not improve or change practice. The service was working within the principles of the Mental Capacity Act. The manager and the provider had a clear vision for the development of the service so that people can achieve the best outcomes possible.

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 3 October 2018).

Why we inspected

We received concerns in relation to people being secluded which prompted us to carry out a focused inspection. As a result, we undertook a focused inspection to review the key questions of safe, effective and

well-led. We found no evidence that seclusion had ever been used in this service.

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

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements.

Please see the safe, responsive and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. The provider has taken action to mitigate the identified risks and we have requested regular updates on these actions from the provider.

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

Enforcement and Recommendations

We have identified breaches in relation to management of medicines, assessment of risks and governance of the service.

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

Follow up

We requested 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Community Places

Detailed findings

Background to this inspection

The inspection

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

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

Inspection team

Two inspectors and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience telephoned people's families and had discussions about the quality of care.

Service and service type

Community Places 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. Community Places 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. A new manager had been in post for 3 months and had submitted an application to register. We are currently assessing this application.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 21 November 2022 and ended on 16 December 2022. We visited the service on 21 November 2022 and 30 November 2022.

What we did before the inspection

We reviewed information we received about the service since the last inspection. We asked for feedback and information about the service from the Local Authority and local 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 spoke to 11 family members of people who lived in the home about their experiences of care and support. We spoke to 4 support workers. We walked around the home and looked in people's bedrooms, bathrooms, kitchens and communal areas. We reviewed medicines, care plans, staff recruitment files and incident management forms. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

- Medicines were not always managed safely and were not stored securely or appropriately.
- People had not received their medication as prescribed. There was information missing in people's medication administration record (MAR) charts for medicines and there was no evidence of follow up with health professionals for missed administration of medication.
- Staff had hand-written some medicines on the MAR chart but there were no dates and no double signatures to show that the handwritten entry was correct as per the prescription for the medication.
- One person had received anti-biotics 3 times a day for 4 days when the prescription stated that they should only be taken for 3 days. We asked the manager to report this to the local safeguarding authority because it is not safe to change the dose of some medicines for people with a learning disability without consulting a doctor.

The provider failed to ensure proper and safe management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the manager took immediate action to address the areas that needed improvement.

Preventing and controlling infection

- Effective infection prevention and control measures were not in place.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were not assured that the provider was supporting people living at the service to minimise the spread of infection.
- Open bags of soiled bedding were not appropriately stored and were left under people's coats in the laundry room. There were clothes in a red laundry bag in a person's room and it could not be determined if the clothes were soiled or clean.
- The outer cover of mattresses were split or heavily worn. The mattresses needed to be replaced.
- There was evidence that 2 shower chairs were soiled with debris and rust.

The provider failed to manage the risk of preventing, detecting and controlling infection. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the manager took immediate action to address the areas that needed improvement.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were not always safe because not all risks had been assessed to keep people safe.
- Risks associated with a profiling bed, mattress and bed rails had not been assessed. We asked the manager to complete a risk assessment immediately after the inspection.
- Environmental risks were not adequately assessed to ensure that people were safe. We found that window restrictors were not in place for all windows and risks associated with this had not been identified.
- Cleaning products and sharp objects were not always stored safely and risk assessments were not in place.
- A system was in place to record and monitor incidents but incident forms were not always reviewed promptly. It was unclear if learning was identified from the incidents or whether practice had been improved.

The provider failed to assess the risks to the health and safety of service users receiving care and support. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the manager took immediate action to address the areas that needed improvement.

Systems and processes to safeguard people from the risk of abuse

- People were safeguarded from the risk of abuse and harm because the provider had safeguarding policies and processes in place.
- Staff received appropriate training and were knowledgeable about how to protect people from the risk of abuse and harm.
- When family members were asked if they were encouraged to raise any concerns, they told us, "Yes, I'd be happy to ring straight away with any concerns."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Staffing and recruitment

- There were enough staff on duty to meet the needs of people who lived in the service. The service had some recruitment challenges and used regular agency staff to provide care and support.
- Staff were recruited safely with appropriate employment checks completed.
- Staff told us that they felt supported in the workplace, "Any support needed, whether personal or for work purposes, is offered. Any support required is always there."

Visiting in care homes

- Family members told us that they could visit whenever they wanted.
- There was some frustration following a recent COVID-19 outbreak but, generally, family members were happy that they could visit regularly without the need to make an appointment.

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.

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

- Staff did not always engage with people effectively so that they could take part in a range of activities.
- People's care plans contained important information on people's likes and dislikes and preferred activities and routines.
- People had access to group and individual activities such as sports, swimming and shopping.
- Family members told us that people's clothes were not always washed and ironed correctly. One family member told us, "I asked for [person's] clothes to be ironed. It got going well then lapsed with clothes not ironed again. Sometimes I need to keep mentioning it." Another relative told us, "When they wash them and then dry them in the dryer, they shrink things."

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 used the Picture Exchange Communication System (PECS) to communicate their preferences and decisions. When staff were prompted, by the manager, to support a person to go out, they did not take that person's PECS with them. The manager took immediate action to rectify this.
- People were supported to use an electronic communication device. This enabled the person to have an active conversation with staff, the manager and the inspector.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy in place.
- Family members told us that they were able to raise concerns with the manager, "I raised a concern and it was addressed to my satisfaction."
- Staff told us that they are able to raise concerns with the manager, "If we have any issues, we can talk to the management team or use the suggestion box provided."

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

- Management walk-arounds and audits were not effective. Audits completed in November 2022 did not pick up any concerns identified during the inspection about medication, infection prevention and control or lack of reviews of incidents.
- A review of incident reports showed that there had not been timely reviews or debriefing sessions with service users or staff. This did not evidence learning from incidents
- We asked the manager to make referrals to the local safeguarding team for concerns that were identified during the inspection.

Governance systems were not effective to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the manager took immediate action to address the areas that needed improvement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 management team were open and honest throughout the inspection and feedback process. They acknowledged that improvements were needed.
- The manager had a clear vision for the direction of the service which demonstrated ambition and a desire for people to achieve the best outcomes possible.

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

- The service engaged and involved people using the service and their families.
- Family members told us, "[Person] and I are involved a lot. The staff or I explain things and [person] understands some of it. I am involved and well informed in decision-making."
- The service worked in partnership with local health and care services. Families were involved in these discussions, "Community Places are really good at that. We have regular meetings on Teams with the doctor, social worker and everybody. We do that every few months."

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 The provider failed to ensure that care and treatment was provided in a safe way for people. Regulation 12(1)(2)(a)(h)(g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. Regulation 17(1)(2)(e)