St Anne's Community Services

St Anne's Community Services- Doncaster

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 4, 5 and 8 May 2016 and was unannounced. This inspection was carried out to review the progress on meeting the regulations and shortfalls identified at previous inspections .

We inspected St Anne's Community Services - Doncaster in February 2015 when we found two breaches of Regulations. These were regarding the safe management of medicines and lack of effective governance. The service received an overall rating of Requires Improvement following the inspection. We inspected the service again in November 2015. We did not find significant improvements at this inspection nor did we have evidence that where improvement had been made, they had been sustained or embedded to enable us to change the ratings given at the February inspection.

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

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

At this inspection we identified continued shortfalls and repeated breaches of the regulations. The arrangements in place for protecting people from abuse or the risk of abuse were not sufficient to protect people, particularly from financial abuse.

Previous inspections in February and November 2015 had identified concerns in relation to medication which have not been addressed sufficiently. For example, we found two instances where prescribed creams were in use, yet did not have a medication administration record to capture the frequency or detail of application.

We saw that people's risk assessments and support plans in relation to keeping people safe were generic and did not name the person they related to.

We spoke with staff about how they raised concerns to the provider. One told us that out of hours management was sometimes difficult to contact when incidents occurred. Another told us that they had raised concerns and did not feel the provider had responded.

We found the service was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). We spoke with the registered manager and other managers within the service about this. They believed that

they could lawfully deprive people of their liberty, and spoke about making applications to do so. The Registered Manager lacked understanding of the legal requirements of the Deprivation of Liberty Safeguards in relation to support living services.

We found that the provider did not appropriately seek people's consent, and on occasion obtained consent from other people on people's behalf, despite them having the mental capacity to give or withhold consent themselves.

We checked records of staff training and found that the training programme was comprehensive, and enabled staff to undertake training in specialist areas that would enable them to better understand the needs of people using the service. Our observations during the inspection indicated that the training was not always put into practice or effective.

Staff meetings had not taken place at the provider's required frequency, and topics discussed were limited.

We observed staff interacting with people and saw that they spoke with people respectfully and kindly.

Care plans lacked personalisation. In one part of the service, all the care plans were extremely similar, and did not contain individualised information and showed little evidence that people had been involved in their care.

There was a system in place for people to have a monthly meeting with their keyworker where their care plan and support was discussed. We found that such reviews had not always taken place in the three months preceding the inspection and in one instance the last recorded meeting was in October 2014.

Activities appeared to be plentiful, and people we spoke with described that they went out often.

A complaints policy and procedure was in place. People told us that they would be happy to raise concerns and would speak to staff or management if they needed to.

The arrangements in place for monitoring the quality of the service provided were poor. The service had a registered manager, however, the registered manager was only responsible for around 20 percent of the service; their role within the organisation meant they had no control or influence over the rest of the service.

The registered manager told us they carried out audits of care plans, audits of medication and checks of people's finances. They were unable to describe any other areas they monitored. We found that care plan audits were inaccurate and did not reflect the records that we had checked.

We looked at statutory notifications submitted to CQC by the provider, and compared them to records of incidents that had happened within the service that the provider was legally required to notify CQC about. We found there were numerous incidents that the provider had failed to submit notifications for.

Some medication did not have dates recorded showing when it had been opened, and stock records were inadequate as staff had not recorded any medication carried forward from one month to another. This meant that the provider had failed to act when CQC found shortfalls in medicines management in November 2015.

In the months preceding the inspection, incidents had occurred within the service where money belonging to people using the service had gone missing. We found there were insufficient systems in place to protect

people from financial abuse.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration the service will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Risks to people were not consistently managed to make sure they received the correct care they needed.

The management and administration of medicines had not sufficiently improved and was not consistently safe.

The arrangements in place for protecting people from abuse or the risk of abuse were not sufficient to protect people.

Is the service effective?

Inadequate

The service was nor effective.

People's rights were not effectively protected because staff did not fully understand or adhere to the Mental Capacity Act 2005.

The provider did not always appropriately seek people's consent.

Staff received regular training that enabled them to better understand the needs of people using the service.

Is the service caring?

Requires Improvement

The service was not always caring.

Care plans generally lacked personalisation.

Records did not always evidence that people had been involved in their care.

Staff knew people and their needs well, and could describe people's preferences and how they wished to be supported.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Care plans were not person centred and lacked the detail

required to provide consistent, high quality care and support.

Reviews of care plans and people's needs was not always carried out within the specified timeframe..

A complaints policy and procedure was in place. People told us that they would be happy to raise concerns and would speak to staff.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager was not responsible for the whole service.

Accurate records on the care and treatment people received were not maintained.

Checks to assess the quality and safety of the service were not effective.

The provider had failed to submit statutory notifications to CQC when required to do so.

St Anne's Community Services- Doncaster

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4, 5 and 8 May 2016 and was unannounced. There were two inspectors in the inspection team who attended on all three days. We met and spoke with five people receiving services from St Anne's. We spoke with the registered manager, area manager, two service managers and five other staff.

We looked at 11 people's care and support records and care monitoring records in detail. We also looked at people's medication administration records and documents about how the service was managed. These included staff training records, audits, meeting minutes and quality assurance records.

Before the inspection the registered manager of the service had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection we reviewed the PIR and information about incidents the provider had notified us of, the provider's action plans from previous inspections and safeguarding meeting minutes. We also spoke with the local authority.

Inadequate

Is the service safe?

Our findings

At our previous inspection in February 2015 the service was in breach of regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.We found lack of effective systems in place for safe administration of medication.

At this inspection we found insufficient improvements had been made. Medication received into the home was not always recorded on the medication administration record (MAR). We found two instances where prescribed creams were in use yet did not have a MAR to record the frequency or detail of application. There was no recorded liaison with the supplying pharmacist to resolve this issue identified. We also found that not all creams had an 'opened on' date. Whilst audits were carried out on the medicines stocks and records, these checks were ineffective and failed to spot any of the concerns, errors and discrepancies that we found during our visit. It is essential to have a robust system of audit in place in order to identify concerns and make the improvements necessary to ensure medicines are handled safely. Previous inspections in February and November 2015 had identified concerns in relation to medication which have not been addressed sufficiently.

We looked at risk assessments in people's care plans to check that they were sufficient to protect people from harm. In two of the houses we saw that people had risk assessments in relation to travelling in staff's cars. Each one was generic and did not particularly apply to the person concerned. One person's risk assessment, in relation to fire risk, stated that they must not have unsupervised access to their kitchen. There was no evidence that they had consented to this or best interest decision made. In one part of the service we saw that people's risk assessments and support plans in relation to keeping people safe were completely generic and did not name the person they related to.
This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements in place for protecting people from abuse or the risk of abuse and found that they were not sufficient to protect people. Prior to the inspection there had been incidents where money belonging to people using the service had gone missing. In response to this, the provider had introduced a system of checking people's money more frequently. We checked this system and found that it had not identified incidents of concern. For example, in one of the houses, people using the service contributed a sum of money to "household finances." This account had been used to pay for staff's travel insurance for supporting people on holiday, however, St Anne's own policy covered this so it was an unnecessary expenditure. This had not been identified by way of any monitoring of people's money. Another person was paying staff's fuel bill to take them to a volunteer work placement, but this placement had offered to pay the person's travel expenses. Again, the monitoring of people's finances had failed to identify this.

We looked at how decisions were made to ensure people's money was spent safely, but found that the arrangements in place were poor. Some of the people using the service contributed to the cost of satellite TV services. Where people lacked capacity to understand this expenditure, there were no records showing

how the decision to spend this money had been reached. This meant that it was not clear that their finances were being safeguarded. Staff had received training in safeguarding, and the provider's records showed that this was an on-going programme. However, when incidents of abuse or suspected abuse had occurred the provider had not always made notifications to CQC, which is required by law.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We spoke with staff about how they raised concerns to the provider. One told us that out of hours management was sometimes difficult to contact when incidents occurred. Another told us that they had raised concerns and did not feel the provider had responded.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. Staff we spoke with did not have a good understanding of the MCA, and some thought that they could lawfully deprive people of their liberty.

We found the service was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards (DoLS) are part of MCA 2005 legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. We spoke with the registered manager and other managers within the service about this. They believed that they could lawfully deprive people of their liberty, and spoke about making applications to do so. As this service was not a care home this would be illegal. We discussed our concerns in relation to this with the registered manager and a member of the provider's senior management team during the inspection.

We looked at the arrangements for obtaining and acting in accordance with people's consent. We found that the provider did not appropriately seek people's consent, and on occasion obtained consent from other people on people's behalf, despite them having the mental capacity to give or withhold consent themselves. For example, one person had made a major purchase. Their care plan stated that they had mental capacity but their relatives had given "consent" for the purchase. We asked the registered manager about this. They said that the relatives had been contacted as a "matter of courtesy" but could not explain why the person themselves had not given consent.

Another person's care plan stated that they were vulnerable to financial abuse due to a lack of mental capacity, but there was no capacity assessment available which supported this. One person's file showed that they did not have mental capacity in relation to finances, however, they were consenting to staff taking their cash card and PIN number. There was no evidence that a formal decision in relation to this in line with the MCA had been taken in their best interests, and no records of who had contributed to the decision making process.
This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We checked records of staff training and found that the training programme was comprehensive, and enabled staff to undertake training in specialist areas that enabled them to better understand the needs of people using the service, in addition to training that the provider's policies stated were mandatory. We asked one staff member about the available training and they confirmed that the training opportunities were "tremendous". Our observations during the inspection indicated that the training was not always put into practice or effective. They told us that they received regular supervision, and said they felt they received good support from their line manager. We asked the registered manager about supervision of staff. They said that six sessions per year took place, however there was no central monitoring system to evidence this.

We looked at records of staff meetings to check that staff received effective communication from managers. Meetings had not taken place at the provider's required frequency, and topics discussed were limited. We asked a staff member about how they received information from the provider but they were unsure about this.

Requires Improvement

Is the service caring?

Our findings

We observed staff interacting with people and saw that they spoke with people respectfully and kindly. Staff knew people and their needs well, and could describe people's preferences and how they wished to be supported. People we spoke with told us they enjoyed receiving support from St Anne's and liked the staff who supported them. People's personal interests were well supported. One person told us how staff had helped them develop their garden and another told us they enjoyed helping around the house.

Previous inspections had highlighted deficiencies in care planning. We found that sufficient improvements had not been made. We looked at people's care plans to check that they set out how people should be cared for, but found in many cases they lacked personalisation. In one part of the service, all the care plans were extremely similar, and did not contain individualised information. The manager of this part of the service told us that this was because they had only been operating for a few months and it was their intention to add personalised details to care plans in the future. However, when a service is new, and staff do not know the people they are supporting well, personalised care plans are essential so that people are supported in the way they have been assessed as requiring.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Two of the people using the service were related to each other and, according to staff, did everything together. We checked their care plans and found that there was just one care plan for the two people. Part of this care plan stated that staff must respect the confidentiality of both people, however, their confidentiality could not be maintained when the care plan contained personal details about both of them.

People's care plans showed little evidence that they had been involved in their care. There were people's signatures in some, but not all, of the care plans we checked. There was a system in place for people to review their care with their keyworker on a monthly basis, although this had not taken place at this frequency in the care plans we looked at.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in November 2015, we found that the provider did not always maintain an accurate and complete record in respect of each person who used the service, including a record of the care and support provided and the decisions taken in relation to the care and support provided.

At this inspection we checked people's care plans to see if they reflected people's needs. One person's care plan stated that they had a specific health condition and required a certain diet to enable them to manage this condition. However, it did not set out what the diet was.

We looked at how people's care was reviewed to ensure it still met their needs. There was a system in place where people had a monthly meeting with their keyworker, in which their care plan and support was discussed. We checked records of these, and found that in many of the files we looked at such reviews had not taken place in the three months preceding the inspection and in one instance the last recorded meeting was in October 2014. This meant the provider could not be assured that people's care and support provided was in a safe way and remained suitable to their needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We reviewed how people participated in activities and holidays. Activities appeared to be plentiful, and people we spoke with described that they went out often. People had been on holidays within the UK and abroad, with staff support, and further such holidays were booked. We asked a staff member how decisions were made in relation to where people went on holidays. They told us that they were discussed in house meetings, although none of the house meeting minutes we checked reflected this. The provider's own policy stated that each holiday taken should be set out in a planning form, where people's decisions would be recorded. None of the files we checked contained holiday planning forms.

A complaints policy and procedure was in place. People told us that they would be happy to raise concerns and would speak to staff or management if they needed to.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in February 2015 2014 the service was in breach of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.We found lack of effective systems in place to monitor the quality of the service delivery.

At this inspection we looked at the arrangements in place for monitoring the quality of the service provided. The service had a registered manager, however, the registered manager was only responsible for around 20 percent of the service; their role within the organisation meant they had no control or influence over the rest of the service. One part of the service, a sizeable block of flats, had begun operating six months prior to the inspection. The registered manager had never been to this part of the service. This meant that they were legally responsible for areas of provision that they did not have oversight of.

We asked the registered manager to tell us about their arrangements for monitoring quality. They told us they carried out audits of care plans, audits of medication and checks of people's finances. They were unable to describe any other areas they monitored. We looked at the monitoring records for care plans, but found that they were inaccurate and did not reflect the records that had been checked. For example, one of the care plans the registered manager had audited contained a risk assessment which did not relate to the person concerned, and another had not been signed by any staff despite there being a form for staff signatures. These shortfalls had not been identified by the audits. We pointed out to the registered manager that the audits did not reflect the evidence in the care plans, and they said that they had "got carried away ticking."

We looked at the medication that the registered manager said had been audited, but found that the system was not well managed. At the inspection of November 2015, we identified that medication was poorly managed, and told the provider they must take action to address this. At this inspection, we found that there were no records at all for some people's medicines, meaning that it was not possible to check what had been administered, or by whom. Some medication did not have dates recorded showing when it had been opened, and stock records were inadequate as staff had not recorded any medication carried forward from one month to another. This meant that the provider had failed to act when CQC found shortfalls in medicines management in November 2015. We discussed this with the registered manager, who told us that they planned to implement improvements, however, the provider had told us previously that they had already introduced these improvements, although we found that this was not the case.

In the months preceding the inspection, incidents had occurred within the service where money belonging to people using the service had gone missing. In response to this, the provider had implemented a new system of storing and checking people's money, however, we found that this was not checked in a meaningful way. For example, one person had signed a contract agreeing how much money they would contribute each month to the household finances; this agreement was inaccurate and they were actually contributing one hundred pounds more per month than the agreement stated. Two of the people using the service had spent a large amount of money on a recreational facility. The provider's policy stated that there

should be records of the decision making process in relation to this. There were no records available. We asked the registered manager what they had done in relation to protecting people from further financial abuse. They said: "With the best will in the world, if someone wants to do it [take service user's money], they will do it."

We asked the area manager how they monitored the quality of service provision. They provided us with an audit document, although this had not been completed. They said it was their intention to commence the audits soon. This showed the governance in place was not effective.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at statutory notifications submitted to CQC by the provider, and compared them to records of incidents that had happened within the service that the provider was legally required to notify CQC about. We found there were numerous incidents that the provider had failed to submit notifications for. These included incidents where the provider had failed to administer people's medication correctly, and other incidents of suspected abuse. We asked the registered manager about how they ensured incidents were appropriately notified to the Commission. They said they oversaw this by talking to the other managers within the service. When we pointed out that this had been ineffective and had resulted in them failing to comply with legal requirements, they could not explain any remedy they might take to address this.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not always notify the Commission of incidents which occurred whilst services were being provided including abuse or allegations of abuse in relation to service users. 18(1)(2)(e)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider not not always carry out, collaboratively with the people, an assessment of their needs and preferences for care and treatment. 9(3)(a) The provider did not always design care or treatment with a view to achieving service users' preferences and ensuring their needs were met 9(3)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have appropriate arrangements in place to ensure that care and treatment of service users was provided with the consent of the relevant person. 11(1)

Regulated activity	Regulation

Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Proper and safe management of medicines was not always observed. 12(1)(2)(g) Risk assessments in people's care plans were not always sufficient to protect people from harm. 12(1)(2)(a)

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
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Arrangements in place for protecting people from abuse or the risk of abuse were not sufficient to protect people. 13(1)(2)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always; Assess, monitor and improve the quality and safety of the services. 17(1)(2)(a) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. 17(1)(2)(b) Maintain securely an accurate, complete and contemporaneous record in respect of each service user. 17(1)(2)(c)

The enforcement action we took:

Warning notice