St Anne's Community Services

St Anne's Community Services - Phoenix Court

Inspection report

16-18 Phoenix Court
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on 12 January 2016 and was unannounced. At the time of the inspection there were seven people living at the home.

Phoenix Court is a care home registered to provide personal care with nursing for seven adults with learning disabilities. The home is a detached property located in a residential area of Todmorden close to the town centre. The accommodation is provided in single rooms on two floors. Each floor has a kitchen, a lounge and communal bathrooms and toilets.

The last inspection was carried out on 13 November 2013. At that time we found there was one breach of regulation relating to the safety of the premises. The provider sent us an action plan with details of the actions they planned to take. During this inspection we checked and found the provider had taken appropriate action.

The registered manager had been in post for approximately a year at the time of the inspection. 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.

People living at the home were safeguarded from abuse. Staff were trained to recognise and report abuse and understood their responsibilities in this area. There were enough staff to meet people's needs and all the required checks were carried out before new staff started work. This helped to protect people from the risk of receiving care and treatment from staff unsuitable to work in a care setting.

People's medicines were managed safely. There were processes in place to check medicines and we saw when errors had occurred actions had been taken to ensure people were safe and reduce the risk of it happening again. However, we found the Commission had not always been notified about these incidents.

The home was clean, well maintained and there was evidence of on-going redecoration and refurbishment. People living at the home were involved in choosing the décor for their bedrooms.

The home was working in accordance with the requirements of the Mental Capacity Act 2005 which meant people's right were protected.

People were supported to have a varied and nutrition diet which took account of their individual needs and preferences.

People needs were assessed and planned for; people were supported to have access to the full range of NHS

services.

Person centred care was promoted by a model of care called Positive Behaviour Support (PBS). PBS is promoted by BILD (British Institute of Learning Disabilities) as the preferred approach when working with people with learning disabilities who exhibit behaviours described as challenging.
People's care and support plans provided detailed information about how each person preferred their care and treatment to be delivered.

People were supported to maintain relationships with family and friends and to take part in leisure activities in the home and in the community.

The complaints procedure was made available to people who used the service.

The home had a warm and friendly atmosphere and we observed a lot of positive interactions between the people who lived there and staff. The registered manager was enthusiastic and open and staff told us they were well supported and enjoyed working at the home.

The provider had systems in place to assess and monitor the quality of the services provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's relatives told us they had no concerns about people's safety and welfare. Staff were trained to recognise and report any concerns about people's safety and wellbeing.

There were enough staff to support people. Robust recruitment procedures helped to make sure people were protected from harm.

People's medicines were managed safety.

The home was clean and well maintained.

Is the service effective?

Good

The service was effective.

People's rights were protected because the service was working in accordance with the requirements of the Mental Capacity Act 2005.

People were supported to have a variety of nutritious food and drink which took account of their likes and dislikes.

People were supported to meet their health care needs and have access to the full range of NHS services.

Staff received the induction, support and training they required to support people and meet their needs.

Is the service caring?

Good

The service was caring.

People's privacy, dignity and individuality was respected.

People were supported to maintain and develop relationships with family and friends and had access to advocacy services when needed.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and their care and support plans reflected their individual needs and preferences.

People were supported to take part in a variety of social activities both in the home and in the community.

People were given information about how to raise concerns or make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a positive and open culture. People were supported to live active lives and staff told us they felt supported and enjoyed working at the home.

Although appropriate action was taken following incidents which had an impact on people's safety and welfare the Commission was not always notified about these incidents.

St Anne's Community Services - Phoenix Court

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 12 January 2016 and was unannounced.

The inspection was carried out by two inspectors.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and speaking with the local authority contracts and safeguarding teams and contacting other professionals who are involved with the home. Before the inspection visit the provider sent us 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.

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. We observed how people were cared for and supported in the communal areas and observed the meal service at lunch time.

During the inspection we spoke with two support workers, the cleaner and the registered manager. After the visit we spoke with two people's relatives by telephone.

We looked at three peoples care records, a selection of medication records, staff records which included their recruitment files and training records and other records relating to the management of the home such as maintenance records, meeting notes and audits. We looked around the home at a selection of people's

bedrooms, communal bath and shower rooms and the communal living rooms.

Good

Is the service safe?

Our findings

People's relatives told us they had no concerns about people's safety and wellbeing. They said the staff were, "Very happy and very positive" and supported people to make the most of their abilities.

The provider had policies and procedures in place which were designed to protect people from abuse and improper treatment. These included whistle blowing procedures which provided staff with information about how to raise any concerns they might have about people's safety and welfare. Staff received training about safeguarding and the staff we spoke understood what abuse was and how to report it.

We looked at medicines and how they were administered. People's medicines were administered by the nurse in charge. We observed and the nurse explained the process for administration. One person had their medicines administered at a time. For each person, the nurse checked the medicines were present before checking details of each medicines against the Medication Administration Record (MAR). The nurse then took the medicines to each person and stayed with them until they had taken all their medicines. Each person had a profile picture and a description of how they took their medicines. We saw the nurse followed this guidance. Stock balances for medicines in tablet form were checked upon each administration. This meant any errors were identified quickly and could be responded to in a timely fashion.

We checked the storage and stock of medicines and found all medicines were stored in line with good practice guidance. However, when we looked at the controlled drugs cabinet we found medicines for two people were recorded with the incorrect quantity in the controlled drugs register. We asked the nurse about this. They explained that one person's medicines had been signed out when they went on holiday but not signed back in when they returned. Another person had recently received a delivery of new medicines, which had been recorded on the MAR but not been entered in the controlled drugs register. We were satisfied the correct amount of medicines were present. This was discussed with the registered manager as a potential area of risk and they provided assurances they would deal with it.

Some people who lived at the home had seizures which required a fast response from staff to administer a certain medicine. Nursing staff were trained to administer this medicine. The registered manager told us support staff had been trained and were in the process of having further in house training to enable them to safely support people who have seizures, outside of the service. When staff supported people outside the service there was a clear procedure in place which directed them to call the emergency services in the event of people having a seizure which required the administration of this particular medicine.

In people's care records we saw risks to their safety and wellbeing were identified. Risks had been assessed and there was information about how the risks should be reduced and managed. We saw risk assessments in place for areas such as chocking, closing the bathroom door when in use, screaming during personal care, having no concept of danger and being in crowded places. Risk assessments looked at the area of risk, potential hazards, ways to reduce the risk and the risk was given an overall rating. This rating made each risk very easy to understand. In some cases we found positive risk assessments. These assessments acknowledged there was risk associated with something the person wanted to do, but the benefits of them

doing this task outweighed the risk. For example we found one positive risk assessment on becoming ill while on holiday.

Phoenix Court was a purpose built property designed to accommodate people with a learning disability. The accommodation was provided on two floors. The corridors and doorways had been widened to make it easier for people who used wheelchairs to get around. Kick boards had been placed on the lower half of walls so damage was not caused by equipment being moved around. Downstairs the communal areas and some bedrooms were fitted with a ceiling hoist. This meant people with limited mobility still had access to the whole house. Bedrooms were decorated to suit people's individual needs and preferences. For example, four bedrooms had a feature wall and were different colours. One person made use of a hospital bed that could be adjusted and another person had an electric chair to aid them with standing. Hinges on some door openings were covered to prevent people's fingers getting caught in high traffic areas. The service benefitted from a garden to the back and a patio area to the front. Staff told us these areas were used frequently during the summer months.

We saw equipment had been serviced and maintained. Staff told us they always completed visual checks before using any equipment. We looked at a selection of maintenance records and found they were up to date. This included fire, gas, electricity and water. There was an emergency plan in place and personal emergency evacuation plans (PEEP) had been completed for each person who lived in the home. In addition, there were 'grab files' for each individual. These were files that could be grabbed quickly in an emergency and they included essential information about each person's abilities and support needs.

Recruitment was organised and co-ordinated by the providers head office. The registered manager was involved in the short listing and interviewing of staff. Potential candidates were invited to visit the home during the recruitment process. They were introduced to people who lived there and the registered manager and staff observed how they interacted with people and how people responded to them. This information was used to inform recruitment decisions. We looked at files of three recently recruited staff and found all the required checks had been carried out before they started work. This included proof of identify, references and a criminal records check. This helped to make sure people were protected from the risk of being supported by people who were unsuitable to work with vulnerable adults.

The registered manager told us the usual staffing levels were one registered nurse and three support workers during the day, 7.30am to 10pm. Overnight there were two waking staff which consisted of one registered nurse and one support worker. The registered manager was not included in the staff numbers unless they were covering for one of the nurses. The service also employed a housekeeping assistant who worked 16 hours a week. The registered manager told us staffing levels were kept under review to take account of the needs of people who lived at the service. They told us since they had taken up their post in January 2015 staffing levels had been increased. They said this had helped to make sure people were able to get out more.

At the time of the inspection the service was advertising to fill two nursing staff posts, one full time and one part time. The vacant hours were being covered by existing staff included the registered manager and agency nurses. The registered manager explained they used a small number of agencies and tried whenever possible to get the same nurses to help maintain continuity of care.

The provider had disciplinary procedures in place. There were processes in place to make sure concerns about staff that held professional qualifications were reported to their professional organisations if required. The registered manager gave us a recent example of how the disciplinary procedures had been used to address concerns about unsafe practice.

We found the home was clean and odour free. The kitchens had been inspected by the Local Authority environmental health department in February 2015 and given a rating of 5, (the highest) for standards of cleanliness and hygiene.

Good

Is the service effective?

Our findings

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 Act 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Before the inspection the registered manager had informed the Commission four people who lived at the home e had DoLS authorisations in place. This was confirmed during the visit. The registered manager told us applications had been submitted for the remaining three people and they were awaiting the outcome.

We saw information in people's care records which showed their capacity to make specific decisions was assessed. Some people who used the service were deemed not to have capacity. However staff told us they were still supported and encouraged people to make small day to day decisions about their life and what they wanted to do. We saw best interest meetings had taken place when big decisions needed to be made, for example, in relation to decisions about care, treatment and spending large amounts of money.

We asked staff about their understanding the MCA and DoLS. They were able to tell us about the MCA and what it meant in relation to their day to day work. They also demonstrated a clear understanding of the Deprivation of Liberty Safeguards. They knew who had a DoLS in place and the reasons why.

In one person's records we saw they had three conditions attached to the DoLS authorisation. There was evidence in the records that the conditions were being adhered to. We saw one person who lived at the home had an audio monitor in their room which staff told us was used overnight. Staff explained the reasons why the monitor had been put in place. However, when we looked at the records we saw the use of the audio monitor had not been included as a restriction in the DoLS paperwork for this person. We discussed this with the registered manager. They were aware the use of the audio monitor constituted a restriction of the person's liberty. However, they said they had not been aware it had been omitted from the paperwork. They said there had been issues with a former member of staff not completing paperwork to the required standard and assured us they would deal with it immediately.

In the records we looked at we saw each person's file contained a support plan on how to support them with nutrition. The nutrition support plans identified people's dietary likes and dislikes. For some people there was increased risk when eating and this had been assessed. A detailed description of the support required when eating informed staff how people wanted to be supported. We saw one person had an

increased risk of malnutrition. A nutritional assessment had been carried out using a recognised assessment tool. The MUST (Malnutrition Universal Screening Tool) is a tool to help identify if someone is malnourished and the information is used to help develop an appropriate support plan. The person's weight was being monitored every week.

In another person's records we saw they had experienced significant weight loss. This had led to a referral being made to an external health care professional and a support plan had been put in place which had resulted in the person regaining their weight.

We observed people over lunch time. Staff made food fresh and sat down with people while they ate. People had menus planned for the week ahead so shopping could be completed prior to each menu starting. The menus were planned around people's individual needs. Some people needed additional calories to maintain a healthy weight while others were following a diet plan to help them reduce their weight. The food looked appetising and healthy. People who required support when eating their meal had staff sat next to them to help when needed. A relative told us they had noticed there was always plenty of fresh fruit and vegetables in the kitchen when they visited, as well as the, "Naughty things". They said there relative was well fed and enjoyed their food.

We saw people's care records included information from health professionals. There was evidence of involvement by GPs, dentists, epilepsy nurse specialists, speech and language therapists and the community learning disability team. Support staff told us if they required advice from a health professional, they would immediately liaise with the nurse to make a referral. Some people had ongoing support from health professional in order to maintain their health and stability on a day to day basis. A relative told us staff at the home were always very quick to contact the doctor or other health care professional if they had any concerns about people's health.

Staff were supported to develop their knowledge and skills to ensure they were equipped to meet people's needs. New staff completed a structured induction training programme, the Care Certificate. In the staff files we saw new staff were supported during their induction by regular review meetings which monitored their progress. There was a training matrix which provided details of all the training staff were required to undertake and how often it should be updated. This included training on safe working practices such as moving and handling, fire safety, infection control, safeguarding and emergency aid. In addition to training on safe working practices, staff received training on topics such as person centred care, positive behaviour support, epilepsy, dementia awareness, diabetes and end of life care. Staff involved in the administration of medicines received training which included annual competency assessments. There was a planned programme of staff supervision and appraisal, supervision took place approximately every two months and appraisals were annual. Staff told us they felt supported and enjoyed working at the home.

Good

Is the service caring?

Our findings

During the SOFI observation we saw evidence of positive relationships between people who lived at the home and staff. We saw staff sitting down chatting with people, laughing and sharing a joke.
We observed one support worker place their hand gently on top of the hand of the person they were speaking with to comfort them. We saw staff called people by their preferred names as recorded in their care records.

The staff we spoke with were able to give us examples of how they protected people's dignity. For example, on the day of inspection we noticed a curtain covering a bathroom door. We asked staff about this. Staff told us, and the person's care records confirmed they did not like doors being closed when in the bathroom. The service had tried different doors to protect their dignity but they did not like it. Staff then tried a curtain to maintain their dignity which worked. Another person's care records indicated they should wear a neck scarf when eating outside of the home. This was a regular scarf that could be removed if food was spilled down it in order to not draw attention and protect their dignity. This showed us staff were aware and conscious of people's dignity and looked for ways to protect it.

We found people were supported to maintain relationships with family and friends. A relative told us they could visit whenever they wanted and said they took their relative out whenever they could. Staff told us family members and friends were encouraged to visit the service when they could. We observed in the entrance hall a note to visitors indicating a nurse was always present to speak with. There was also information which showed the home would support family or friends to stay overnight at the service with people if they were ill.

Advocacy information was available in the home and people told us staff had access to advocacy services as and when needed. In one person's records we saw an advocate had been involved in best interest meetings where decisions were being made about different aspects of their life, for example health and finances.

We looked in some people's bedrooms with their permission. We saw people's rooms were decorated and furnished to reflect their individual tastes and needs. A relative told us their relative, who lived at the home, had been involved in decorating their room. They had chosen the colour scheme and the bed linen. This demonstrated recognition of and respect for people's individuality.

Person centred care was promoted by a model of care called Positive Behaviour Support (PBS). PBS is promoted by BILD (British Institute of Learning Disabilities) as the preferred approach when working with people with learning disabilities who exhibit behaviours described as challenging. PBS is based on the use of least restrictive practices and is fundamentally rooted in person centred values, aiming to enhance community presence, increasing personal skills and competence and placing emphasis on respect for the individual being supported. The provider, St Anne's, has achieved BILD accreditation and the registered manager was a PBS instructor.

Good

Is the service responsive?

Our findings

People's relatives told us they were kept up to date with any changes in their relatives' needs or circumstances. They said they were very happy with the care and support provided at Phoenix Court. One relative said they felt the staff were, "Very interested in [person's name]."

We looked at the three people's care records. The care records included a pen picture of the person which included essential contact details. Each person had photos of themselves in their record so it was easy to see who the records belonged to. People's files included information about their likes and dislikes. For example, we saw one person liked to sit on their own but did not like sitting in direct sunlight and enjoyed trying new foods but disliked herbal tea. In another person's records we saw they liked to stay in bed late in the morning and disliked the cold. This showed us records were detailed and tailored to each person's needs and preferences.

The care records were divided into sections describing the different areas of support people needed. We saw support plans for behaviour, cognition, communication, mobility, continence and further areas individual to each person. Each section provided staff with detailed information about how each person wanted their care and support delivered.

There are a number of documents recognised by the Commission and health professionals which help to support people with a learning disability more effectively. We found these documents were used at Phoenix Court. For example, we saw people had Health Action Plans (HAP), VIP medical travel card and a plan of achievable goals. The care records contained a list of goals for each person. Goals were decided with each person during their review. For example one person had achieved their goals in 2015 to go to a zoo twice and get a new floor for their bedroom. One person's relative told us they were always invited to the review meetings and if they were unable to attend they were informed of the outcome.

Staff told us they liked the care records and found them useful to follow. We observed people being supported by staff in line with their care records. For example, we observed one person being supported to walk to the bathroom in the way described in their care plan. This showed us care records enabled staff to respond to people's needs.

People who required specific support needs had additional guidelines for support in their plan. For example, there was one person who had behaviour that challenged. The person's care records contained 'behavioural guidelines', a description of how their behaviour manifested itself and a checklist to prevent behaviour which was challenging. These documents were person centred and full of details specific to the individual.

We spoke with staff about the activities that people did. Staff said they supported people to identify activities they wanted to try and helped them organise these when they could go. The service had a leisure activity's book which listed a range of activities for people to take part in. For example, we saw people had their hair and nails done, went for drives out and about in the car, went to the cinema, went horse riding and had enjoyed a day out at the races. Staff told us people went out twice a week on average. They said they

tried to encourage people to try new things based on current interests. For example, one person showed signs of really enjoying the bath and water so on the day of inspection staff had organised to take this person to the swimming pool. This showed us people had opportunity to take part in activities they liked and were supported to try new experiences.

The registered manager told us they had not received any formal complaints in the past year. They said one person's family had spoken with them about some concerns and these had been dealt with immediately. Relatives told us they were comfortable talking to the manager or a member of staff if they had any questions or concerns. One relative said they had never had any problems but were confident they would be listened to if they had.

There was an information leaflet in the home, titled "Compliments, Complaints, Suggestions". It provided a clear guide for people on how to raise concerns and what to expect from the provider. It included information about advocacy services and other organisations people could contact if they were not happy with the way the provider dealt with their concerns.

Requires Improvement

Is the service well-led?

Our findings

We found the home had a calm and friendly atmosphere and this was echoed by the relatives we spoke with. People told us the staff and registered manager were approachable and one relative said staff had a "vitality" about them which meant people who lived at the home were supported to live active lives.

The registered manager had been in post approximately one year at the time of the inspection. They told us they had put an improvement plan in place when they started work at Phoenix Court and continued to use this to help identify improvements to the service and monitor progress. The plan covered areas such as staff training and development, staff recruitment, communication, care planning and the premises. The plan was reviewed every month with the area manager when they visited the home. For example, the registered manager had identified improvements were needed to the shower room and bathroom on the first floor and at the time of the inspection improvement work was scheduled to start on both these rooms.

The registered manager provided a monthly report to the Local Authority and used this format to help them monitor and audit the service. The areas covered included staffing, agency use, staff supervision and appraisal, disciplinary actions, team meetings, accidents and incidents and actions taken and complaints and the outcome.

The area manager carried out monthly audits of the service, focusing on different areas each month. This audit covered areas such as safeguarding, duty of candour, team meetings and accidents and incidents. In addition, random audits were carried out by the provider, for example in May 2015 one of the regional management team had carried out an audit of the care documentation.

The registered manager told us over the past year they had identified a number of concerns about the way medicines were managed. They had taken actions to address these concerns, for example, they had changed their pharmacist and moved away from a Monitored Dosage System to boxed medicines. They had implemented daily checks on the numbers of tablets in stock and an independent pharmacist had carried out two audits of the medicines management systems. We found when medication errors had an impact on people's safety and welfare action had been taken to protect people and the concerns had been reported to the Local Authority safeguarding team. However, the Commission had not been notified about all these incidents. This was discussed with the registered manager who acknowledged it was on oversight and gave an assurance it would not happen again.

The registered manager told us they had asked the local NHS control of infection team to visit the home and carry out an audit. They said they would use this as a baseline to assess and monitor infection control practices.

The provider obtained feedback from people's relatives and other stakeholders by means of an annual survey. This had been sent out in November 2015 and at the time of the inspection the registered manager was waiting for detailed feedback on the results. They said the initial feedback had been positive.

The registered manager said they had tried questionnaires with people who lived at the home but found this was not very effective. Instead they monitored how people were on a daily basis, looking for subtle changes in people's behaviour which could indicate they were unhappy about something. They told us each person had regular care reviews and people and their relatives were involved in the review. In addition, people were supported to access advocacy services. This was supported by the relative we spoke with and the records we looked at.

Staff told us they received sufficient support to complete their roles. One avenue of support was given through team meetings. We saw team meetings were held monthly to discuss any changes or for information to be passed onto staff. Each meeting had a set agenda as well as additional items to be discussed if they were needed. Agenda items covered previous meeting minutes, service user welfare, activities, property matters, staff matters and training. We saw one meeting record promoted service user choice and empowering clients. Nurses also had a separate meeting to discuss the clinical aspects of support and changes or information that affected their job role. Nurse meetings were held every three months. In addition, the provider engaged the services of an external organisation to carry out a staff survey every year.