Care Quality Commission

Cristal Care Limited

The Pleasance

Inspection report

Edlington Lane
Edlington
Doncaster
South Yorkshire
DN12 1PL

Tel: 01709868651

Date of inspection visit:
13 December 2022
14 December 2022

Date of publication:
24 February 2023

Ratings

Overall rating for this service	Inadequate ●

Is the service safe?	**Inadequate** ●
Is the service well-led?	**Inadequate** ●

Summary of findings

Overall summary

About the service
The Pleasance is a residential care home providing accommodation and personal care to 12 people at the time of the inspection. The service can support up to 15 people. The Pleasance has 5 houses on 1 site each having individual flats with communal living space and enclosed gardens. People with learning disabilities and autistic people use the service.

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.

People's experience of using this service and what we found
Right Support:
The provider failed to have safe and robust systems in place when incidents and accidents occurred. Risk management was poor and failed to identify and address all known risks. Staff were not provided with enough clear guidance to support people safely. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care:
People did not experience continuity and consistency of care from a staff team that knew them well. We found that at times, people were left unsupported which compromised their wellbeing. Staff interacted with people with warmth and respect.

Right Culture:
There was a lack of consistent and effective oversight from the provider and the registered manager regarding quality assurance. Risks were not always reduced to ensure people were safe. The registered manager had not consistently submitted notifications to the Care Quality Commission or made referrals to the local authority and police in respect of all reportable incidents.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good (published 01 May 2018).

Why we inspected
This inspection was prompted by a review of the information we held about this service since the last inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report. Following the inspection, the provider evidenced they had taken action to mitigate some of the risks we identified on this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to safety, safeguarding, governance, staff training and the environment at this inspection.

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 met with the provider following the inspection. 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 with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Care Quality Commission

The Pleasance

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 2 inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Pleasance is a 'care home'. People in care homes receive accommodation and personal and nursing care as a single package under one contractual agreement dependent on their registration with us. The Pleasance 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 a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and 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 all this information to plan our inspection.

During the inspection
We spoke with 7 relatives and 5 people using the service. We also spoke with 10 members of staff, including the registered manager, area manager, senior support worker, support workers, an administration assistant and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We checked a number of records including 4 care files, 2 staff files, audits, checks and records relating to the management and oversight of the service. We reviewed the medicines administration records for 5 people. We reviewed recent medicines audits and medicine error incident forms and subsequent learning from these.

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; Learning lessons when things go wrong
● People were at significant risk of harm as known risks had not been adequately assessed and reduced. Concerns were found in multiple areas of people's support needs including; fire safety, public safety and environmental safety." 'Following the inspection the provider updated risk assessments to reduce risks to people.
● The service did not consistently keep people safe by sharing emerging risks with health and social care professionals in a timely manner.
● At the last inspection we identified that risk management plans did not
cover how to reduce risks during the night-time for people living with epilepsy. The registered manager at the time, gave us assurances these
risks would be looked at and risk management plans would be updated to cover night-time checks. At this inspection night-time risks had still not been addressed. After the inspection the provider contacted the epilepsy nurse and suggestions were made for them to follow. The provider then put in place assistive technology to give assurances epilepsy could be safely monitored at night.
● Accidents and incidents were not effectively recorded and analysed by staff. Incidents that should have been shared
with the police and the local authority had not been reported. Information was not used to help
reduce the risk of repeated events and to make continuous improvements.

Whilst no harm occurred, the provider failed to ensure systems were in place to demonstrate risks were properly assessed, reviewed and actioned and were not doing everything that was reasonably practical to mitigate risks. This placed people at risk of harm. This was a breach of regulation 12 (1) (2) (a) (b) (d) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities)
Regulations 2014.

● The premises and peoples personal belongings were not appropriately secure. Following the inspection, the provider addressed these security issues and strengthened them.

The provider had failed to ensure premises were appropriately secure. This placed people at risk of harm. This was a breach of regulation 15 (Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we had detailed discussions with the provider about their failure around management and oversight of risk strategies. We requested immediate action be taken in relation to specific areas of concern to ensure people and the public were safe. The provider acted responsively to the concerns

and strengthened their systems.
● Each person had a positive behaviour support plan in place. This helps staff to understand young people and adults who have a learning disability and who may use behaviour as a way of communication. Care plans and risk assessments were also in place and were person centred, however they had not always effectively reduced all known risks.
● Safety checks in relation to fire, gas, legionella, electrical safety and portable appliance testing (PAT) was seen to be in place. Personal emergency evacuation plans (PEEP) were in place for each person.

Staffing and recruitment
● Staff were not always effectively deployed to meet people's needs. People were not consistently receiving one to one support where this was required. We observed staff leaving people without their agreed support to gather cleaning items so they could carry out domestic duties. Records also showed an incident where a staff member left a person unsupported which resulted in them choking on food. There was an investigation carried out by the provider and appropriate action agreed to reduce further risks. Despite this, we found other examples where people were left unsupported placing them at risk of harm.
● Staff training for medicines administered by specialised techniques had not been updated annually or signed off by a healthcare professional to ensure staff competency, as stated in the providers medicines policy.

The provider had failed to ensure that staff received appropriate training and had been effectively deployed to meet people's needs. This was a breach of regulation 18 (1) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment checks were undertaken prior to staff starting work. These included references and Disclosure and Barring Service (DBS) police checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding systems and processes were not robust to ensure people were always protected from the risk of abuse.
● Safeguarding concerns were not always reported by the provider as required. We asked the provider to make 2 referrals to the police and safeguarding team following this inspection. We also made these referrals to the police and safeguarding team under our reporting duties. We raised concerns with the provider following the inspection that all the necessary information relating to safety concerns had not always been fully disclosed to professionals.
● Training in safeguarding was not always effective. We saw training had been provided. However, safeguarding incidents had not always been recognised and reported by staff or the management team.

The provider had failed to maintain effective scrutiny over safeguarding issues and had not effectively implemented and operated robust procedures to protect people from abuse. This was a breach of regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Policies and procedures were in place to safeguard people from the risk of abuse.
● Staff and relatives told us people were safe. One relative said, "[Name] is safe and wouldn't be happier anywhere else."

Preventing and controlling infection

● Infection prevention and control measures were not effective in identifying concerns.
● Staff were not always wearing face coverings or wearing them appropriately. There had recently been an outbreak of COVID-19 and 1 person was still testing positive for the infection. We saw the registered manager on the first day of our inspection reiterating to staff the necessity to wear masks, but on the second day of our inspection staff were not consistently following instructions to wear masks.
● The service was not clean. During our walk around of the service we noted some areas in need of a deep clean, and some flooring that needed replacing as it posed an infection hazard. We discussed this with the nominated individual who took action to ensure deep cleans were carried out. The provider told us that replacement flooring had been ordered.

We recommend the provider consider current guidance on ensuring people are protected from the risks of infection and take action to update their practice accordingly.

● Supplies of PPE were available in the service. Staff told us there was plenty of PPE available for them.

Visiting in care homes
● The provider was supporting visiting in line with government guidelines.

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. Any conditions related to DoLS authorisations were being met.

Using medicines safely
● People received the correct medicines at the right time. People's medicines were regularly reviewed to monitor the effects of medicines on their health and wellbeing. Staff followed systems and processes to safely administer, record and store medicines.
● Detailed guidance specific to each person on how to administer medicines to be taken as and when required (PRN) was available.
● Instructions for medicines to be given at specific times were available. Administering medicines as directed by the prescriber reduces the risk of the service user experiencing adverse effects from the medicine, or the medicine not working as intended.
● There were individual balance checks of quantities and stocks of medicine supplied for each person. This meant that we were assured medicines had been given when signed for by staff on the medicine's administration record.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

● The service had a registered manager at the time of the inspection. The provider had strengthened their management structure since the last inspection and were carrying out closer governance checks of the service in the form of health and safety and quality assurance audits. However, the provider's processes had failed to identify breaches of regulation found during this inspection.
● The registered manager and provider had failed to ensure the quality assurance systems were reliable, robust and effective to drive improvements. For example, they did not pick up the areas found at this inspection such as building security, training, safeguarding and risk management.
● The provider's systems and processes had not enabled the registered person to identify where quality and safety were being compromised and to respond appropriately and without delay as reported in the safe domain of this report.
● The registered manager had not always identified risks and introduced measures to mitigate the risks in a timely manner that reflected the level of risk and impact on people using the service.

We found no evidence people had been harmed. However, the provider had failed to have effective systems in place to assess, monitor and improve the quality of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had regular team meetings with staff to gather their views and to share information. The provider had also carried out night time checks on the service and met with night staff.

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 registered manager had not always reported incidents to the police, safeguarding nor submitted notifications about incidents as they are required to do by law to CQC. The providers lack of oversight meant this had not been identified.

Failure to notify CQC as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This is being followed up outside of the inspection process and we will report on any action once it is complete.

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

● Person centred care was promoted, and people were supported to take part in activities which they enjoyed and had links to the local community. Whilst people told us they were happy living at The Pleasance and relatives said they were satisfied with the care, we identified areas where staff did not consistently provide one to one support to people which had impacted on their safety and wellbeing.

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

● We received mixed feedback on the management of the service. One relative said, "The manager is approachable, I wouldn't change anything." Another relative said," The manager takes it as criticism if I approach them and I am the one suggesting things like speaking to the social worker."
● The provider encouraged people, relatives and staff to share feedback verbally and with questionnaires which were sent out by the provider.
● Relatives felt they were kept informed about the service and the care provided.
● The provider worked in partnership with other organisations to provide people with joined up care.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to maintain effective scrutiny over safeguarding issues and had not effectively implemented and operated robust procedures to protect people from abuse. This was a breach of regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to have ensure premises were appropriately secure. This placed people at risk of harm. This was a breach of regulation 15 (Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.