St Anne's Community Services

St Anne's Community Services - North Tyneside DCA

Inspection report

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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?	Outstanding ☆
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 19 and 21 March 2018 and was announced. This was to ensure someone would be available to speak with us and show us records.

St Anne's Community Services - North Tyneside DCA is a domiciliary care agency. It provides personal care to adults living in their own houses in the community. On the day of our inspection there were nine people using the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

We last inspected the service in February 2016 and rated the service as 'Good.' At this inspection we found the service remained 'Good' and met all the fundamental standards we inspected against.

The service provided exceptionally person-centred care. Person-centred means the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

People were involved in the running of the service. The registered manager told us, "Clients are at the centre of everything we do and they lead the services that we provide."

The service was exceptional at supporting people to maintain their independence and staff treated people with dignity and respect.

People had 'Accessible information' support plans in place. The accessible information standard was introduced in 2016 to ensure anyone with a disability, impairment or sensory loss is given information they can easily read or understand. The plans described how people communicated, what their preferences were and how staff could support them with their communication needs.

Accidents and incidents were appropriately recorded and risk assessments were in place. The registered manager understood their responsibilities with regard to safeguarding, procedures had been followed and

staff had been trained in safeguarding vulnerable adults.

Appropriate arrangements were in place for the safe administration and storage of medicines.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff. Staff were suitably trained and received regular supervisions and appraisals.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Care records showed that people's needs were assessed before they started using the service. People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

Activities and holidays were arranged for people who used the service based on their likes and interests and to help meet their social needs.

People who used the service and family members were aware of how to make a complaint.

The provider had an effective quality assurance process in place. Staff said they felt supported by the registered manager. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

Further information is in the detailed findings below.

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 remained Good.	**Good**
Is the service effective? The service remained Good.	**Good**
Is the service caring? The service improved to Outstanding.	**Outstanding** ☆
Is the service responsive? The service remained Good.	**Good**
Is the service well-led? The service remained Good.	**Good**

St Anne's Community Services - North Tyneside DCA

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 19 and 21 March 2018 and was announced. This was to ensure someone would be available to speak with and show us records. One adult social care inspector carried out the inspection.

Inspection site visit activity started on 19 March 2018 and ended on 21 March 2018. It included a visit to the provider's office on both these dates to speak with the registered manager; and to review care records and policies and procedures. We also visited five people in their own homes.

During our inspection we spoke with five people who used the service. Some of the people who used the service had complex needs which limited their verbal communication. This meant they could not always tell us their views of the service so we carried out observations and spoke with three of their family members. In addition to the registered manager, we also spoke with the deputy manager, five members of staff and contacted two social care professionals. We looked at the care records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is

information about important events which the service is required to send to the Commission by law. We contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe with staff at St Anne's Community Services - North Tyneside DCA. One family member told us, "We are happy [name] is safe. The staff know we are at the end of the phone." Another family member told us, "They [St Anne's Community Services - North Tyneside DCA] have really tried hard with our [relatives]' changing and complex health needs, and numerous admissions to hospital to make sure they are safe and supported."

People were provided with information in an easy to read format on how to keep themselves safe. For example, who can access their home, how to check for identification and the need to let a member of staff know about their whereabouts if they were going to be away from home.

There were sufficient numbers of staff on duty to keep people safe and engage in activities. We discussed staffing levels with the registered manager. They told us rotas were prepared in advance so staff had plenty of notice of what shift they were working. People were supported by small staff teams to ensure continuity however agency staff were occasionally used to cover short notice absences. When agency staff were used, they worked alongside an experienced member of staff. The registered manager told us staff were flexible, willing to work unsociable hours and change shifts at short notice to meet the needs of the people they supported. Staff we spoke with confirmed this.

A family member told us they had concerns about the out of hours arrangements for care staff in case of emergencies. The registered manager explained the service had a 24 hour helpline and staff who worked on the helpline had the details of all the people who used the service, including their health needs. They told us the helpline provided support and practical assistance in case of an emergency out of hours. Staff on the helpline also had contact numbers for the area managers who could be contacted in case of an emergency. We saw a copy of the provider's out of hours advice line procedure that described the steps to be taken in case of emergency or serious incident.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed new staff to ensure they were suitable to work with vulnerable people. The recruitment process included input from people who used the service and family members.

Accidents and incidents were appropriately recorded and analysed to identify what the contributory factors were and whether any lessons could be learned from the event. For example, whether a change to the person's environment or different equipment was required, or whether staff involved required additional training or support.

Appropriate risk assessments were in place for staff and people who used the service. The registered manager told us, "Clients decide what they would like to do and we will do everything in our power to support them to do this. Ensuring risk assessments are completed to keep clients as safe as possible, whilst also giving them as much freedom and independence as possible." This meant the provider had taken

seriously any risks to people and put in place actions to prevent accidents from occurring.

The registered manager was aware of their responsibilities with regard to protecting vulnerable adults, they understood safeguarding procedures and had followed them. We saw copies of alerts made to the local authority, details of investigations carried out, copies of statutory notifications sent to CQC and copies of 'Client desired outcomes statements.' These recorded discussions that had taken place with the person involved. For example, whether they wanted safeguarding enquiries to be made and actions taken, and what things they would like to change as a result of the concerns raised. A social care professional told us safeguarding incidents had been appropriately dealt with and resolved.

The provider's business continuity plan described the action to be taken in the event of an emergency. Risks to people's safety in the event of a fire had been identified and managed. Information was available in each home to advise staff what to do in the event of an emergency. For example, where to turn off the gas, electricity and water supplies. We saw how one person was supported to carry out their own health and safety checks in their home. These included checking doors were locked and electrical items were turned off at night, and weekly checks of the first aid box and fire alarm.

The provider's infection prevention and control policy described important issues relating to infection control and emphasised the importance of all staff following good basic hygiene procedures. A risk assessment was in place and all staff received training in infection control when commencing employment with the service. This training was refreshed every two years.

We found appropriate arrangements were in place for the safe administration and storage of medicines.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. A family member told us, "[Name]'s carers are marvellous. I can't speak highly enough of them." Another family member told us, "They have matched [staff] quite well. We are quite happy." A social care professional told us staff were appropriately trained and people who used the service received "appropriate levels of support".

Staff were supported in their role and received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff mandatory training was up to date. Mandatory training is training that the provider deems necessary to support people safely. New staff completed an induction to the service and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Person specific training was sourced from other services and health professionals and the registered manager told us they used the local care alliance and local authority as much as possible to access training, such as dementia awareness. People who used the service were also encouraged to attend training such as fire safety, first aid, diabetes and social media safety.

People's needs were assessed before they started using the service and continually evaluated in order to develop support plans.

The service provided effective support for people with dietary needs. For example, one person had been diagnosed with dysphagia, which is difficulty swallowing food. The person had been referred to a speech and language therapist (SALT) and had a meal plan in place that included a fork mashable diet. Another person was fed via a percutaneous endoscopic gastrostomy (PEG), which is a means of feeding via a tube passed into the stomach.

One person's diet had been reviewed by the SALT and had been changed to a pureed food diet. It was identified the person was not enjoying their meals as they looked unappetising and they struggled to identify what they were eating. The staff team researched and bought individual food moulds so food could be moulded, for example, pureed carrot went into a carrot mould. The registered manager told us the person started to enjoy their food again and their weight improved. Another person had identified they were putting weight on and wanted support to lose weight to become healthier. Staff worked with family members to ensure that if the person was going to visit their family, meals and snacks were consistent and in line with their healthy eating plan. The family also bought a slow cooker for the service and provided some healthy recipes the person could make with their staff team.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this for the people who use domiciliary care services are carried out through the court of protection. We saw people's capacity to make decisions was recorded and where necessary, best interest decisions had been made involving family members and staff.

Records showed that consent had been obtained from people where necessary. For example, care and treatment, photography and video use. Where people were unable to sign, this was documented on their records.

People had health action plans in place and were supported to attend health appointments. Health action plans included information about the person's health, people who were involved with their support and important medical information. The ambulance service had been contacted to ensure that in an emergency the people from one of the homes where they were supported were taken to a certain hospital as this was where the people felt comfortable, as well as familiar with the staff. A meeting had been arranged with the learning disability nurse at the hospital to provide information on the people's needs, communication and support required so this could be added to the hospital notes and systems. We saw hospital grab bags were in place in case of an emergency.

The service had regular meetings with day services to ensure they were aware of any changes or concerns and could provide their support. Each person took a communication book with them to day services so any issues or comments could be passed on.

Care records included details of any appointments with health care professionals, and included records of any outcomes, actions or guidance. These included visits to and from GPs, dentists, opticians, SALT, physiotherapists and psychologists.

Outstanding ☆

Is the service caring?

Our findings

Family members told us the service was exceptionally caring. A family member told us, "They [staff] are very caring." Another family member told us, "Very caring" and "[Name]'s happy. That's all you want." Another family member told us, "They [St Anne's Community Services - North Tyneside DCA] have been a big part of our family" and "We have had some lovely days out together with our [relatives], as well as tea parties etc, all supported by the staff from St Anne's." A social care professional told us, "They are person centred. They put [people who used the service] first."

There was a strong, person-centred culture at the service. Person-centred means the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

People were involved in the running of the service and were invited to attend 'People's voice' meetings where they could discuss the service such as things that were going well or not so well, and specific topics such as disability hate, safeguarding and inclusion. The registered manager told us, "Clients are at the centre of everything we do and they lead the services that we provide."

Staff were particularly sensitive to when people needed caring and compassionate support. For example, when a repair was being carried out at a person's home it was found some structural work was required. This meant the person could not stay in their home for ten days. It was arranged for the person to stay in a holiday home at the seaside while repairs were being carried out. To prevent the person from becoming upset or worried about this change to their routine, it was described to them as an exciting, last minute holiday, which made them feel positive instead of concerned about it. The registered manager told us the holiday went so well that the person was planning another holiday at the same location.

The service was exceptional at supporting people to maintain their independence. Personal care assessments described what people could do for themselves and what they needed support with. These included hair care, bathing, dressing, nail care, dental hygiene, continence and mobility. For example, one person could wash and bathe themselves but required support from staff when in the shower due to the risk of slips, trips and falls, and required prompts for personal care tasks such as washing their hair. The person was able to dress themselves but required support to choose the correct clothes for the weather conditions

The service had supported a person who had recently been diagnosed with dementia to stay as independent as possible whilst attending to their personal care. The service contacted an occupational therapist and requested an assessment which resulted in the person having a bath lift fitted. This meant the person was able to get in and out of the bath safely and could attend to their personal care independently, ensuring they kept as much dignity as possible. We observed one person making their own lunch at a kitchen workbench that was designed at a height so they could access it in their wheelchair. This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

Our observations confirmed staff treated people with dignity and respect and care records demonstrated

the provider promoted dignified and respectful care practices to staff. A staff member described how they gave a person privacy and maintained their dignity when they were supporting them to have a shower. A family member told us, "They [staff] all take that [privacy and dignity] on board. They definitely give privacy to [name]."

People had 'accessible information' support plans in place. The accessible information standard was introduced in 2016 to ensure anyone with a disability, impairment or sensory loss is given information they can easily read or understand. The plans described how people communicated, what their preferences were, how staff could support them with their communication needs and whether they used any pictures or symbols to aid their communication.

For example, one person could communicate verbally and let their needs be known but may require staff to repeat information so they could understand what was being said, and give them time to answer. Their support plan stated, "Staff must make sure that any choices I make are my choices and I am not being influenced by others." Alternative methods were used by the service to support people with their communication needs. For example, two other people whose care records we looked at could communicate verbally but used a program on their electronic tablet to help with their communication via pictures and symbols. This system enabled people to express their views and wishes with staff and others.

People were respected and valued as individuals. For example, staff identified a person had an interest in the armed forces and emergency services. They were supported to attend an army event where they got special access and were a VIP for the day with the Royal Horse Artillery. Another person who used the service had family members living abroad and wanted to contact them. They were supported by staff to buy an electronic tablet and supported to learn how to use it so they could video call their family members and send them emails and photographs of activities and holidays. Another person was interested in music and meeting new people so staff supported them to find a local group of musicians. This resulted in the person playing with the group on a regular basis.

People we saw were well presented and looked comfortable in the presence of staff. People were assisted by staff in a patient and friendly way and it was noticeable from our observations how people had a good rapport with staff. Staff interacted with people at every opportunity, sharing stories and laughing at jokes. Staff were aware of people's individual likes and dislikes and made conversation about their interests, using personal items to help trigger memories and help support the person with their communication needs.

People's preferences were clearly documented in their care records. For example, whether they would prefer male or female staff to support them with their personal care, personal care choices such as bathing, shaving and dressing, and the preferred name they wanted to be addressed by.

We saw that records were kept securely at the provider's office and in people's own homes, and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

The registered manager told us none of the people who used the service had religious or spiritual needs but this was considered when developing support plans.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the registered manager who told us one of the people using the service at the time of our inspection had an

independent advocate. Advocacy information and contact details for local advocacy groups was made available to people in their care records.

Good

Is the service responsive?

Our findings

Care records we looked at were person-centred, regularly reviewed and evaluated. Each person's care record included important information about the person such as next of kin, GP and care manager contact details, the level of assistance required with daily tasks and a pen picture of the person. 'This is me' records were also in place for each person and described in detail the person's history, things that were important to the person, important people in the person's life, likes and dislikes, and their daily routine. We saw these had been written with the person and their family members.

Support plans were in place and included personal hygiene, oral health, health and wellbeing, medication, communication, emotional needs, behaviour support, sleeping and resting, and eating and drinking. Support plans described the task/objective, the steps to take to complete the task, what support was required from staff and whether there was an identified risk. Where required, risk assessments were in place. For example, the support plans for people who were unable to mobilise independently described how staff were to support them when mobilising from their bed to a wheelchair, armchair or shower chair. The support plans described how they accessed the community using their wheelchairs and the support they required to do this. For example, how many staff were required to support them, whether they could travel on public transport or whether they required a specially adapted vehicle. Appropriate risk assessments were in place.

Handover files were maintained at each home where support was provided. These included communication logs, copies of staff rotas, any correspondence or updates, copies of new policies and procedures, and checklists.

Records described people's routines from waking in the morning to going to bed at night. These included the times people liked to wake in the morning and go to bed at night, personal care preferences, and details of any appointments and planned activities.

The majority of people supported by the service were young adults so they did not have end of life support plans in place. The registered manager told us this would be discussed with families at the appropriate time. 'Client information sheets' recorded whether people wished to be buried or cremated, and also recorded if the person did not wish to discuss the matter.

We found the provider protected people from social isolation. People's daily activities were documented in their care records. For example, we saw one person went to a day service three times per week, enjoyed activities of their choice on other days, and enjoyed going out with friends or to a local social club. Another person enjoyed watching football and had a season ticket for their local football team. Some of the people used social media to keep in touch with family and friends. People were also supported to book pampering sessions such as massages, manicures and pedicures.

People went on holidays supported by the staff they chose. Recent holidays included Blackpool, Manchester, Butlins Skegness, the Calvert Trust and Ibiza. A family member told us the service was unable to

support them with a weekend holiday that would include extended family members. As a result of being unable to support the family at this time, the registered manager arranged a multi-disciplinary team meeting and funding that should have gone to the service was provided to the family so they could arrange their own support for the holiday. The family member and a social care professional confirmed this. The social care professional told us staff regularly supported people on holiday.

'Social, leisure and employment assessments' were carried out for each person. These described whether the person could access the community independently, whether they could organise social activities themselves, potential employment opportunities and whether they could develop safe, personal relationships. For example, a person had attended the provider's office to arrange an Easter party. They devised a poster invite, which was sent out to other people who used the service. One person told us about the activities they enjoyed and we saw photos of places they had been whilst supported by staff. The person was a member of a local gym and had a specific support plan in place for this.

The provider had a 'dealing with compliments, complaints and suggestions' policy in place. This was to ensure feedback was positively encouraged and all complaints were handled in a fair and consistent manner. An easy to read version was made available for people who used the service and described what to do if the person or their representative was unhappy about something or had a complaint to make, and how long it would take for a complaint to be resolved. The registered manager told us complaints were discussed with people at monthly meetings. There had not been any recorded complaints or compliments at the service in the previous 12 months.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered since January 2018. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months. They told us they were looking into assistive technology to support people with personal security and to extend the use of an electronic medication system that was already in use for one person.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The management team were involved in forums such as the North East registered managers' meetings, Newcastle care providers' meetings, and learning disabilities forums, and gathered information that could be cascaded to the staff teams through staff meetings and personal development reviews.

Staff we spoke with felt supported by the management team. Staff were regularly consulted and kept up to date with information about the home and the provider, and staff meetings took place monthly. One member of staff told us, "I get lots of support. There's always someone at the end of the phone" and "We have a great team." Another member of staff told us, "It's one of the better care companies to work for." Another member of staff told us, "It's a great team."

The service had good links with the local community and local organisations. They linked up with local organisations and services such as the 'Safe place scheme', which meant the provider's office was a location that provided a safe, accessible and friendly environment for people who needed it. People who used the service attended events in the local area. For example, a local hotel for events and overnight stays, a local theatre and local training events on how to stay safe. Coffee mornings in aid of charity were held at the provider's office.

The service had a positive culture that was person centred and inclusive. The registered manager told us they regularly invited family members to the office for a chat and a coffee, and this helped to reduce issues and complaints. They told us, "We try to get the families involved as much as possible. It's nice to involve them. I would want to know what was going on." Family members told us they felt involved and could approach the registered manager and staff at any time. One family member told us, "If we do have a problem, we get it sorted quite quickly", "We get involved in all [name]'s reviews" and "They [registered manager and staff] take everything on board." Another family member told us, "If there are any issues, they are immediately addressed", "If I need to, I ring [registered manager] up. She involves me. I feel very comfortable approaching her" and "I'm really satisfied with the service all round." Another family member told us, "Overall St Anne's provides a very good standard of care and we look forward to continue working with the team in the best interests of our family members in the future." A social care professional told us the management team "bend over backwards" to support people.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. The provider had a quality assurance policy in place that had three main themes; the promotion of quality, to seek assurances that the service had the right indicators and intervention took place when there were concerns.

The provider's area manager conducted monthly visits to the homes where the regulated activity was carried out. These visits were based on the CQC five key questions of safe, effective, caring, responsive and well-led, and included a review of records, observations and discussions with staff and people who used the service. An action plan was put in place for any identified issues.

The registered manager carried out a monthly audit at each home where the regulated activity was carried out. These checked general housekeeping, risk assessments, any premises or equipment issues, medication, finance and records. If any issues were identified, these were recorded and actioned.

Daily, weekly and monthly checks were carried out by staff at each home and were recorded. These included safety checks such as home security, visual checks of equipment, hot water temperatures, electrical checks, medication stock checks, first aid and fire safety. Weekly update sheets on any issues were completed by staff and sent to the office.

'Client meetings' took place regularly at each home and included discussions about any issues, activities and holidays, staffing, health and safety, and anything else people would like to discuss.

Annual questionnaires were carried out for people who used the service, their family members and other stakeholders. Questionnaires for people who used the service were in an easy to read format and included questions on trust, being listened to, involvement in decisions, safety, overall satisfaction and whether their support had got better, stayed the same or got worse since they started using the service. Questions for family members included safety, quality of the service, knowledge of how to make a complaint, communication and management. A family member told us, "We give honest feedback to surveys."

An action plan was put in place should any issues arise from the survey however all of the responses we saw were positive. Comments from people included, "I am happy with my staff, they help me if I need something" and "Like staff, help doing jobs in the house, feel happy." Comments from family members included, "The carers and management are open and honest about any issues that might arise and we are included in any strategy meetings relating to these issues", "The staff are on regular rotas and any changes are explained and prepared ahead of time" and "Staff are very caring and supportive, with a good homely feel to the new residence." A social care professional commented, "It has been a pleasure to work with St Anne's" and "St Anne's North Tyneside should be congratulated for the service that is provided."

A newsletter was produced for the service on a quarterly basis and all the people who used the service were invited to submit good news stories and examples of outstanding care for inclusion in the newsletter.