St Anne's Community Services

Aachen Brook St Anne's Community Services

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

Summary of findings

Overall summary

This inspection took place on 16 June 2017. The inspection was unannounced. This inspection was the first of this service since it was registered in November 2015 by St Anne's Community Services.

Aachen Brook provides residential and respite care for up to six people with physical and learning disabilities. Nursing care is provided.

At the time of this inspection there were two people residing at the home and three people receiving respite care. A fourth person arrived for a period of respite care on the day of our visit.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and could speak to any of the staff if they were worried about anything. The manager understood their responsibilities for safeguarding people and staff were trained to understand and recognise abuse. They knew who to report concerns about people's safety and welfare within the organisation and to external agencies if necessary.

Sufficient numbers of staff were deployed to provide people with the care and support they needed. The required checks were done before new staff started work and this helped to keep people safe. Staff were provided with training and support to enable them carry out their roles.

Systems were in place to make sure medicines were managed safely.

People who used the service and their relatives told us staff were helpful, kind, attentive and caring. We saw people were treated with respect and compassion. They also told us they felt safe with the care they were provided with. We found there were appropriate systems in place to protect people from risk of harm.

Risks to people's safety and welfare were identified and managed. Risk assessments clearly identified the risks to people and what could be done to mitigate the risks and keep them safe whilst promoting independence. Staff were provided with information about how to deal with emergencies .

Meals were prepared and cooked by staff with the involvement of the people who lived there as they wished. We saw people's nutritional needs and preferences were taken into account.

We found the service was working in accordance with the Mental Capacity Act 2005 and this helped to make sure people's rights were protected. When there was any doubt about a person's capacity to understand a particular decision the correct process was followed to make sure any actions taken were in their best

interests.

'Health Action Plans' were in place to help support people to lead a healthy lifestyle. These included information about health care professionals involved in supporting people and details of how people were able to communicate health care issues and emotions. The service worked with other health and social care professionals to help achieve positive outcomes for people.

People told us staff respected their privacy and dignity and provided them with the support they needed. Staff demonstrated a caring attitude and we saw the interactions between staff and people who used the service were friendly and warm. People were supported to maintain relationships with family and friends and take part in a range of social activities of their choosing.

People were involved in decisions about all aspects of their care and support.

The care documentation supported a person centred approach and contained all the detail staff would need to make sure people were supported safely and in the way they preferred.

There was a complaints procedure and people were informed of what they should do if they were unhappy. The people we spoke with said they had no reason to complain but would not hesitate to speak with one of the staff or the registered manager if they had any concerns.

There were systems in place to monitor and improve the quality and safety 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.

Staff were trained to recognise and report abuse. The required checks were done before new staff started work. This helped to protect people from the risk of abuse.

There were enough staff to provide people with appropriate care and support and medicines were managed safely.

Risks to people's safety and welfare were identified and managed.

Is the service effective?

Good

The service was effective

Staff received training and support to deliver safe and appropriate care.

People's rights were protected and they were supported to make choices by staff who had a good understanding of the principles of the Mental Capacity Act 2005.

People were supported to have a choice of food and drink which took account of their preferences. Nutritional and healthcare needs were met.

Is the service caring?

Good

The service was caring.

People were provided with all the information they would need about the service.

Staff were kind, friendly and respectful.

People's privacy and dignity needs were met.

Is the service responsive?

Good

The service was responsive.

Care was planned and delivered with a person centred approach which met the needs of people using the service.

People were supported to meet their social and leisure needs.

Information about how to make a complaint was available in formats to meet the needs of people using the service.

Is the service well-led?

Good

The service was well led

The registered manager had the confidence of people who used the service, their relatives and staff.

Systems were in place to monitor and improve the safety and quality of the service.

People's opinions were sought and valued.

Aachen Brook St Anne's Community Services

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 16 June 2017 and was unannounced.

The inspection was carried out by one adult social care inspector.

We asked the provider to complete a Provider Information Return (PIR) which was returned to us in a timely manner. 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 reviewed all information we held about the provider and contacted the local authority and Clinical Commissioning Group (CCG) to ask for their views on the service.

During our inspection we spoke with the registered manager, a nurse, the clinical lead and three support workers. We also spoke with two people who lived at the home, a person who received respite care and two relatives of people who used the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the service. When we asked one person what made them feel safe they said "The staff."

We saw the easy read 'Client guide' given to all people who used the service included a section titled "For Your Protection' which detailed staff responsibilities to make sure people were not abused or experienced anything which they did not like or made them unhappy. In addition there was an easy read safeguarding policy which gave examples of abuse and what people could do if they experienced any abuse or were worried about anything.

Staff we spoke with were able to tell us about different forms of abuse and what they would do if they suspected anybody was at risk. The number for the local safeguarding team and how to raise alerts was available in the office for all staff.

We saw the service had liaised with the local safeguarding team where this had been appropriate.

Checks of environmental safety within the service were robust. We saw audits of the environment and equipment used were completed on weekly, monthly and annual basis and where any issues were identified these were raised appropriately and action taken to address the issue. Weekly audits included such as mattress, wheelchair and moving and handling equipment checks. A monthly premises safety audit was completed and an annual quality and safety audit was completed which followed the key lines of enquiry used by CQC. Safety information was available to all staff which included such as telephone numbers for use in an emergency, and where to turn off gas, water and electricity. A Control of substances hazardous to health (COSHH) file was available with data sheets for all chemicals used at the service. Service inspections of specialist chairs and lifting equipment were up to date.

Risk assessments were in place for all aspects of the environment, working practices and fire safety. Checks on fire safety were made on weekly and monthly basis.

Accidents that happened within the home were recorded electronically and assigned for the overview of the registered manager. Accidents and incidents were analysed at service and provider level for any themes or trends. This meant any identified risks could be identified and addressed.

Individual risks to people who used the service were assessed and included in the person's care file. These measured the risk to people before and after implementation of the risk assessment and gave clear instruction on how to mitigate the risk.

Each person had a detailed personal emergency evacuation plan (PEEP) in place which gave specific details of how the person needed to be supported to leave the building in an emergency.

Staffing levels were set according to the number of people using the service at any one time and also their

dependency needs. Other considerations such as supporting people to go out were also taken into account. On the day of our visit we saw staff were available to spend time engaging with people as well as meeting their support needs.

The registered manager explained they were supported with the recruitment of new staff by the providers Human Resources, (HR), department which was based in Leeds. There was a clear recruitment procedure in place; applicants completed an on-line application form and this information was used to select a short list of candidates to be interviewed. Successful candidates were then required to provide two references and complete a criminal records check with the DBS (Disclosure and Barring Service) before they were offered a position. All new staff had a three day induction to the service prior to starting work and then a period of shadowing experienced colleagues until they felt, and had been assessed as competent. Staff then completed a six month probationary period before their employment was confirmed. This helped to protect people from the risk of being supported by staff who were not suitable to work with vulnerable adults.

We looked at two staff files, which contained information from the providers HR department to confirm all the required checks had been completed and were satisfactory.

We looked at the systems for managing medicines in the service. We saw that when people came to the service for a period of respite, the medicines they brought with them were counted, checked to make sure there was enough for their stay, the medicines had not exceeded their expiry date and that the instructions from the pharmacy were included. All of these checks were made and signed by two members of staff. A stock check of all medicines for people receiving respite care was completed each night. We checked two of these and found them to be correct. When new bottles of liquid medicines were opened, a label was fixed to show the date they were opened. At the end of a period of respite care the person's medicines were counted and checked to make sure the amount remaining tallied with the amounts received and signed as administered.

Medication Administration Record sheets (MARS) were filled in appropriately with the times of medicines highlighted for easy reference. Medication care plans were very detailed containing details of the medicine, what it was used for, any side effects and details of how it was to be administered. The care plans also included photographs of the packaging the medicine was supplied in and an explanation of abbreviations commonly used relating to prescriptions, for example 'BD' meaning to be taken twice each day and 'mg' meaning milligram. These MARs were updated as required and a copy of them included in the person's 'grab file' to go with them if they needed to go to hospital in an emergency.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff. We checked two of these and found them to be correct.

Temperatures of the room in which medicines were stored were recorded on a daily basis. These were appropriate for safe storage as recommended by the manufacturer of the medicines.

We considered the systems in place for managing medicines safely to be of a very high standard.

The registered manager told us that to enhance person centred care, they hoped to have medicine storage facilities installed in each person's bedroom

We found the service to be clean and tidy throughout. A domestic was employed to work 22 hours per week

with support staff also completing cleaning tasks. Cleaning schedules were available detailing which jobs were to done when and by whom.

Information was available relating to cross contamination, cleaning and the chilling and cooking of food to make sure the risk of the spread of infection was minimised. A member of staff had the role of 'Infection control champion'.

Good

Is the service effective?

Our findings

Staff we spoke with told us they received good and effective training and were well supported by the registered manager. One person told us the provider was "really good with training" and said the manager was "really supportive and works shifts instead of staying in the office.

We saw from the training matrix that staff received regular training and updates in such as safeguarding adults, moving and handling, equality and diversity, mental capacity act and record keeping. Staff were able to access training delivered by the CCG and the local authority. Other training relative to the needs of the people who used the service was organised as needed. The training matrix showed staff were up to date with their training.

The registered manager told us all new staff who were new to care were required to complete the Care Certificate training. The Care Certificate is a set of standards for social care and health workers. It was launched in March 2015 to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care.

After completing a three day induction to St Anne's at the provider's head office, staff then had a six month probationary period during which they received a one to one supervision to look at their personal development every six weeks.

Two relatives we spoke with told us staff were "great". One said "They will give me advice even when (relative) is not here for respite".

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 are called the Deprivation of Liberty Safeguards (DoLS).

We saw mental capacity assessments had been undertaken for people who used the service. Where people were not able to consent to the use of equipment which could be seen as restrictive but necessary to maintain their health and safety, for example lap belts in chairs, the registered manager had made applications for DoLS. Although the application we looked at had not been granted we considered the registered manager had acted appropriately in their consideration of restrictive equipment.

This meant the service was working within the principles of the MCA.

The service did not employ catering staff as meals were cooked by support staff and, wherever they wished, people using the service. The kitchen had variable height units and dining table to enable people who used

a wheelchair to be able to prepare food.

Staff told us meals were planned with the people using the service at any one time. For example, on the day of our visit staff had made a sweet and sour chicken as this was a favourite of a person arriving for respite that day. However, when the person arrived and told staff they wanted fish and chips, this was accepted without question as it was the person's choice on that day.

People's weights were monitored and their dietary needs explained in detail within their care plan. For example, we saw one person's file said they received some of their nutrition directly into their stomach through a percutaneous endoscopic gastrostomy known as a PEG but could also eat food. The care plan stated the person should be asked each day if they were eating that day or just having their PEG feed. We heard staff asking the person and letting other staff know what the person had decided on.

The premises were well designed to enable people to move easily between rooms and all rooms were spacious to easily accommodate people using special chairs. Equipment to assist people to maintain their personal hygiene was available to give people choice. For example various bathing and showering facilities were available and also a hydrotherapy pool for people who might enjoy and benefit from this facility. All bedrooms and the bathroom were equipped with tracking hoists.

People who used the service were supported by healthcare professionals such as GP and district nurse along with other specialist professionals such as the multiple sclerosis (MS) and nutrition nurses. Staff told us specialist professionals also assisted in staff training to enable staff to have better understanding and knowledge of the particular condition.

In case of emergency hospital admissions each person had a 'Grab file' this included their VIP passport to inform hospital staff of the person's immediate and specific needs, the person's moving and handling plan, the 'Do not resuscitate' (DNR) if appropriate and the detailed MAR and medicines care plan and information sheet. These were kept up to date to make sure that when people needed to go to hospital, their needs would be known to the hospital staff.

Good

Is the service caring?

Our findings

People we spoke with told us they were very happy with the care and support provided at Aachen Brook. One relative told us "We are so lucky, this is the only place we'd use, the staff are great." Another relative said "It's like a family; (relative) leaves one home and comes to another."

People who used the service told us they felt well cared for. A person who arrived for respite told us they liked to come. We saw staff coming to greet this person on their arrival, the staff were welcoming, saying how nice it was to see them again and the person was clearly happy to see the staff.

We saw people were given a pack of information about the service on their first visit. This information was provided in an easy read format and gave people clear information about what they should expect from the service, what the staff will do and what the service expects from their the service user, for example consideration of other people using the service. The information tells people how staff will maintain their privacy and confidentiality and tells people staff will know what to do if they are hurt by other people, worried or frightened.

A relative we spoke with told us they were involved in their relative's care and had seen their care plan and agreed with its content. Another told us they respected their relative's right to privacy whilst enjoying their respite care as it gave them some independence.

We saw that after each respite stay staff sent a resume of how the person had been and what they had done to their relative. We considered this to be good practice but discussed with the registered manager about making sure the person had consented to this information being shared with their family.

We observed all interventions between staff and people who used the service to be friendly, caring and respectful. Staff were led by the choices and preferences of people.

We saw staff supporting a person who enjoyed a cigarette but were unable to manage this themselves. We saw staff made sure the person was warm enough to go outside and then held the cigarette for the person. Staff did this with patience and chatted to the person as they enjoyed their smoke.

We saw a care plan in relation to end of life. The care plan detailed the person's wishes, how to involve their family, their 'Do not attempt Resuscitation (DNAR) order and said how the person was to be supported with privacy and dignity. We saw a member of staff acted as a 'Dignity champion' and the registered manager told us that following further end of life training, a member of staff would take on the role of 'champion in this area.

We saw a compliment received at the home from the relatives of a person who used the service. The relative had written "We consider ourselves very fortunate that (relative) had you to care for her. You are always prepared to go the extra mile."

Good

Is the service responsive?

Our findings

We saw care was planned and delivered and delivered with an entirely person centred approach.

At the front the care files we looked at we saw a pen profile of the person, their needs and abilities and a statement about the person's capacity to make life changing decisions. Also included was a statement of how the service met the person's needs in relation to accessible information. For example if the person would need to receive feedback from their reviews orally or in writing.

A further profile included a photograph of the person, personal details and details if a 'Do not attempt Resuscitation (DNAR) was in place. This profile included the statement "Provide care with respect and dignity, keep me safe from harm, tell me what you are doing at all times when providing support, ask if you need to know anything or look in my support plan for further information.

The profile detailed the person's health issues, medicines, any aids they used and their communication abilities and needs.

Care plans included all the detail staff would need to make sure the support they delivered met with the needs and preferences of the person and that their safety needs were met. Examples of this were such as the personal care plan including details of the person's preferred toiletries and creams used and how they would like staff to style their hair. The mobility and moving and handling plan included photographs of the sling the person used and a close up photograph of the label on the sling to make sure staff used the correct one and where people used a pressure relieving mattress, contact details for mattress repair were included in the care plan.

Care plans for behaviour and psychological and emotional needs considered how family contact might help and included details of how the person's physical condition and pain would impact in this area.

Details of people's needs and preferences were clear throughout all of the care plans. An example in one person's file was "I dislike other people presuming they know me better than I know myself". Other examples were the care plan for sleeping which gave details of the person's preferred sleeping position and how staff would need to arrange pillows for comfortable positioning and the care plan for leisure which gave specific detail of who the person liked to spend time with, what they liked to do and their preferences about using the mini bus. Actions staff needed to take to ensure people's comfort and dignity were clearly detailed.

In addition to care plans care files included a 'Health Action Plan'. This detailed health care professionals involved in the person's care and their contact telephone numbers, a list of medical conditions and what they mean. General health details were included as well as the person's abilities in relation to the five senses. Information about how people might show feelings such as happy, sad, worried, frustrated and scared was included.

For people who used the respite service a separate document which gave details of their preferred daily and

night time routines was evaluated and updated on each visit.

We concluded the depth of detail available in care records to make sure people's needs and preferences were met demonstrated a high level of commitment to making sure people benefited from a high level of person centred care.

We discussed with the registered manager about how this approach could be enhanced by including detail of how people had been involved in the care planning process.

We saw people were involved in setting personal long and short term goals which included action plans detailing people's strengths, needs and accomplishments.

People were informed of how to make a complaint through a pamphlet included in the pack given to people when they started to use the service. This information clearly explained what people should do, who they could contact and how the service would respond. A complaints procedure was available in the home. People we spoke with said they had not had any cause for complaining but would not hesitate to speak with staff if they did.

People chose how they would like to spend their time and staffing was organised to accommodate supporting people engaging in activities outside the service. We saw photographs of celebrations and events held by the service.

The complaints/compliments file showed no complaints had been received by the service at the time of our inspection but a high level of compliments of the service had been received.

Good

Is the service well-led?

Our findings

A registered manager was in place at the time of the inspection. This person had been registered with CQC as the manager when the provider took over the running of the service in November 2015.

Before the inspection, we asked the provider to complete 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. This document was very well completed and showed us the registered manager was continually looking at ways to improve the service.

People who used the service and relatives we spoke with told us they knew the registered manager and had confidence in them.

Staff told us the registered manager was very supportive and worked some shifts as well as their role as manager.

We found there was a very friendly, open and honest culture in the home. The registered manager told us they believed in complete honesty when discussing the service as they found open discussion could only support improvements.

When we contacted the local authority prior to the inspection they told us that in their view the registered manager had stabilised the service well since St Anne's took over in late 2015. They told us they received few issues from the service and the registered manager is very experienced and cooperative.

We saw robust and effective systems were in place for monitoring the safety and quality of the service. All audits were well documented with any required actions detailed and confirmed when completed. Audits completed by staff working at the home were checked through monthly audits by a senior member of the company.

A system was in place for monitoring and auditing accidents and incidents. This was done at both home manager and provider level.

Surveys were used to gain the views of people involved with the service. Although these were limited in the questions asked, we saw all of the responses received were positive. Results of surveys were analysed and produces in graph form for people to see.

Staff meetings were held on a monthly basis with nurses meetings also held. We saw from the minutes of these meetings that staff were actively involved in the running of the service. The registered manager also showed us evidence of an ad hoc staff meeting which took place as the opportunity arose.

The registered manager told us they had held a meeting for people who used the service but this had not been well attended. They told us they did have good relationships with relatives of people who used the

service and felt confident they would speak to them if they had anything they needed to discuss.