St Anne's Community Services

St Anne's Community Services - Astbury

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 3 May 2017 and was unannounced. This meant the provider and staff did not know we would be visiting. A second day of inspection took place on 10 May 2017, and was announced.

St Anne's Community Services – Astbury consists of two large, modern, purpose built bungalows. The bungalows are connected via a doorway. The service is in a residential suburb of Middlesbrough, with local amenities nearby. The service can provide care and support for up to eight people with learning disabilities and/or autistic spectrum disorder. The service is a care home without nursing. At the time of our inspection eight people were living at the service.

The service was last inspected on 4 December 2015 and 6 January 2016. During that visit we identified a breach of our regulations. Mental capacity assessments did not always take place and decisions made in people's best interests were not always documented. We took action by requiring the provider to send us action plans setting out how they would make improvements. During our latest inspection we found action had been taken and improvements had been made.

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.

Risks to people were assessed and plans put in place to reduce the chances of them occurring. The registered manager monitored accidents and incidents to see if improvements could be made to keep people safe. Plans were in place to keep people safe in emergency situations. Policies and procedures were in place to safeguard people from abuse. People's medicines were managed safely. The registered manager monitored staffing levels to ensure they were sufficient to keep people safe. The provider's recruitment processes minimised the risk of unsuitable staff being employed. The premises were clean and tidy.

People's rights under the Mental Capacity Act 2005 were protected. Mental capacity assessments were documented, and guidance on the decisions people could make themselves and those they would need support with were detailed in people's care plans. Staff received a range of training in order to support people effectively. Newly recruited staff were required to complete the provider's induction process before working with people without supervision. Staff were supported through regular 'personal development review' supervisions and appraisals. People were supported to maintain a healthy diet. People were supported to access external professionals to monitor and promote their health.

Throughout the inspection we saw that support was delivered to people in a kind and caring way. Relatives spoke positively about the support people received, and described staff as caring. Staff had a good knowledge of people and were able to communicate effectively with them. People were encouraged to be as independent as possible and were treated with dignity and respect. Policies and procedures were in

place to support people to access advocacy services and end of life care.

Care and support was based on people's assessed needs and preferences. Staff were knowledgeable about people's support needs and were able to talk in detail about how people liked to be supported. People were supported to access a range of activities based on their personal interests. Procedures were in place to investigate and respond to complaints.

Staff spoke positively about the culture and values of the service and said they were proud of where they worked. Staff spoke positively about the registered manager and deputy manager. The registered manager carried out a number of quality assurance checks to monitor and improve standards at the service. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications.

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.

Risks to people were regularly assessed and action was taken to minimise risk.

People were supported by staff who had been appropriately recruited and inducted.

People were supported to manage their medicines.

Is the service effective?

Good

The service was effective.

People's rights under the Mental Capacity Act 2005 were protected and their consent to care obtained and recorded.

Staff were supported through regular training, supervision and appraisal.

People were supported to access external professionals to maintain and promote their health.

Is the service caring?

Good

The service was caring.

Staff maintained people's dignity and treated them with respect.

Staff were kind and caring.

Procedures were in place to support people to access advocacy services.

Is the service responsive?

Good

The service was responsive.

Care was planned and delivered based on people's assessed needs and preferences.

People were supported to access activities they enjoyed.

Procedures were in place to investigate and respond to complaints.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively about the culture of the service and the registered manager.

Quality assurance processes were in place to monitor and improve standards.

Feedback was sought from people and staff.

St Anne's Community Services - Astbury

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 3 May 2017 and was unannounced. This meant the provider and staff did not know we would be visiting. A second day of inspection took place on 10 May 2017, and was announced.

The inspection team consisted of one adult social care inspector and one 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.

Before the inspection we reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We contacted the commissioners of the relevant local authorities and clinical commissioning group and the local authority safeguarding team to gain their views of the service provided by St Anne's Community Services - Astbury.

People using the service were not always able to communicate verbally. During the inspection we communicated with two people who used the service and carried out observations around the home. We spoke with three relatives of people who used the service. We looked at two care plans, medicine administration records (MARs) and handover sheers. We spoke with five members of staff including the registered manager, deputy manager and support workers. We looked at two staff files, which included recruitment records. We also reviewed records relating to the day to day running of the service.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe. People answered by nodding their heads to indicate yes. A relative we spoke with told us, "Of course they are safe. They wouldn't be there if they weren't."

Risks to people were assessed and plans put in place to reduce the chances of them occurring. For example, one person was assessed as being at risk of falling. Their risk assessment contained guidance on how they should be supported when transferring from sitting to standing to help keep the person safe. Another person had a risk assessment in place for their behaviour that challenges. This contained detail of how the person and people around them could be protected from harm during such incidents. Staff we spoke with said they worked hard to keep people safe. One member of staff said, "My job is to keep the residents safe." Risk assessments were regularly reviewed to ensure they reflected people's current level of risk.

The registered manager monitored accidents and incidents to see if improvements could be made to keep people safe. They gave us an example of a person who had been involved in incidents involving their behaviour that challenges. An assessment was carried out involving other professionals who worked with the person, and this led to new strategies being developed to help the person manage their behaviour.. A member of staff we spoke with said, "We know the residents and we can recognise warning signs so we try and diffuse a situation by taking action before something gets out of control."

The building and equipment was also regularly checked to ensure it was safe for people to use. Fire exits, emergency lights and smoke detectors were checked on a weekly basis. The registered manager carried out an annual fire risk assessment, and fire drills were regularly held. Required test and maintenance certificates were in place, including for hoists, scale, gas and electrical safety and waste disposal.

Plans were in place to keep people safe in emergency situations. People using the service had personal emergency evacuation plans in place (PEEPs). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The registered manager told us how they had sought advice from the fire brigade in drawing up people's PEEPs. There was a business contingency plan in place to help provide continuity of care for people in situations where the service was disrupted.

Policies and procedures were in place to safeguard people from abuse. The provider had a safeguarding policy. This provided guidance to staff on the types of abuse that can occur in care settings and advice on how they should be reported. Minutes of staff meetings showed that safeguarding and whistle blowing were regularly discussed and that staff were encouraged to raise any concerns they had. Whistle blowing is when a member of staff tells someone they have concerns about the service they work for. Staff received safeguarding training and had a good working knowledge of safeguarding issues. One member of staff told us, "Residents are safe from abuse - physical and financial and everything in-between. This is a safe environment." There had been no safeguarding incidents since our last inspection but the registered manager and staff were able to describe how issues would be reported and investigated.

People's medicines were managed safely. Before people started using the service their medicine support needs were assessed, including any relevant risk assessments. These assessments were then used to develop care plans setting out how the person should be supported with their medicines. Each person also had a medicine administration record (MAR). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. MARs contained a summary of the medicine support people received, details of the medicines they took and what they were. MARs we looked at had been correctly completed, and where people had declined their medicines this was appropriately documented. Topical MARs were used to document the use of topical medicines such as creams. Where people took 'as and when required' (PRN) medicines, protocols were in place providing guidance to staff on when these might be needed.

Staff received training in medicine administration and had access to a medicines policy should they need further guidance or support. We observed a medicine round and saw staff took the time to explain to people what their medicines were for and asked if they wanted to take them. Support was delivered at people's own pace, and records were completed after each medicine was taken. This reduced the risk of medicine errors occurring. Medicines were safely and securely stored in locked cupboards. Daily temperature checks were carried out to ensure medicines were stored appropriately. Regular checks of medicines stocks were made to ensure people always had access to their medicines when they were needed. Some people at the service used prescribed controlled drugs, and these were appropriately stored and recorded. Controlled drugs are medicines that are liable to misuse.

The registered manager monitored staffing levels to ensure they were sufficient to keep people safe. Staffing levels changed day to day depending on whether people were attending a local day centre or undertaking other activities in the community. On an average day around five people attended a day centre, with staff from the service escorting them. This meant there were usually three people at home during the day, with at least four support workers in the building to support them. Overnight there were two support workers. The registered manager told us that due to the size of the service staffing levels remained broadly the same, but that people's dependency needs were regularly assessed to see if additional support from staff was needed. Sickness and holiday leave was covered either by staff working extra shifts or bank staff. During our visit we saw staff supporting people at their own pace and responding quickly to any requests for assistance. Staff we spoke with said there were enough staff employed to support people safely. One member of staff said, "The staff balance is just right."

The provider's recruitment processes minimised the risk of unsuitable staff being employed. Applicants for jobs were required to complete an application form setting out their employment history, including any gaps. Identity was checked, references sought and Disclosure and Barring Service (DBS) checks carried out. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and adults.

The premises were clean and tidy. Training was given in infection control and we saw staff using appropriate personal protective equipment (PPE) during our inspection. We also saw staff tidying items away and removing any trip hazards as they moved around the building.

Good

Is the service effective?

Our findings

During our last inspection we identified a breach of regulations. Mental capacity assessments had not always taken place and decisions made in people's best interests were not always documented. We took action by requiring the provider to send us action plans setting out how they would make improvements. During this inspection we found action had been taken and improvements had been made.

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. At the time of our inspection all eight people who used the service were subject to DoLS authorisations. These were clearly recorded in people's care plans, including details of when they expired so timely applications could be made for reauthorisation should this be necessary.

Mental capacity assessments were documented, and guidance on the decisions people could make themselves and those they would need support with were detailed in people's care plans. Care plans also contained records of meetings to discuss decisions to be taken in people's best interests. For example, one person had a best interest decision in place for the use of a wheelchair safety belt. Staff received training on the MCA and DoLS and displayed a good working knowledge of their principles. One member of staff told us, "I know all about DoLS and MCA. I know what they mean and this is to ensure safety, not control. There is a difference."

Staff received a range of training in order to support people effectively. Mandatory training was completed in areas such as moving and handling, fire safety, health and safety, food safety, safeguarding, supporting people with behaviours that can challenge and equality and diversity. Mandatory training is training and updates the provider thinks is necessary to support people safely and effectively. The registered manager monitored training on a training chart. This showed that staff training was either up-to-date or planned. Records of supervisions, appraisals and staff meetings showed that staff were asked about their training needs and whether they wanted any additional support. Staff spoke positively about the training they received and said they were confident they would receive additional training if they requested it.

Newly recruited staff were required to complete the provider's induction process before working with people without supervision. This included completing mandatory training, reviewing the provider's policies and procedures and shadowing more experienced staff to get to know people living at the service.

Staff were also supported through regular 'personal development review' supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Records of these meetings confirmed that staff were asked about any ongoing support needs they had, including training and health and safety issues. Staff we spoke with said they would be confident to approach the registered manager or deputy manager with any issues they had outside of these meetings.

People were supported to maintain a healthy diet. Before they started using the service people's nutritional support needs were assessed and this information was used to develop care plans on how they could be supported. For example, one person used PEG and their care plan set out how this should be managed. PEG is a system used where people having difficulty swallowing foods and fluids. Staff received PEG training in order to support the person effectively. Care plans emphasised how people should be included in managing their own food and drink. For example, one person liked to make their own hot drinks and their care plan set out how they would like to put their drink of choice in a mug before staff assisted by pouring hot water in. People were regularly weighed and the service used recognised tools like the Malnutrition Universal Screening Tool (MUST) to monitor people's nutritional health. MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

The service had two dining rooms, which is where most people chose to eat their meals. We saw that people enjoyed sitting in the dining rooms while meals were being prepared, and that support workers interacted with people as they were making them. There was a six weekly menu that had been developed with input from people at the service, but people were also free to choose anything they wanted to eat. For example, we saw one person change their mind about the breakfast they had asked for and be quickly given something else. We asked the person if they had enjoyed their breakfast, and they nodded and smiled to indicate yes. Some people at the service had 'personalised place mats' that had been developed using an NHS template. These set out in easy read form the person's nutritional support needs, how they could be assisted (for example, with appropriate positioning) and any specialist equipment they needed. There was a food hygiene inspection of the service in March 2017, and the service was awarded the maximum rating of five out of five.

People were supported to access external professionals to monitor and promote their health. People's care plans contained records of the involvement of professionals such as GPs, district nurses, speech and language therapists (SALT), dieticians, occupational therapists and wheelchair services. Records confirmed that people were supported to access such services regularly to receive the healthcare they needed.

Good

Is the service caring?

Our findings

Throughout the inspection we saw that support was delivered to people in a kind and caring way. People looked happy and comfortable around staff and we saw lots of singing and friendly conversations between them. We asked one person if they were happy living at the service and they smiled and nodded enthusiastically to indicate yes. We saw numerous examples of people smiling and laughing during their interactions with staff.

Relatives spoke positively about the support people received, and described staff as caring. One relative told us, "It's like us caring for them to be honest, but probably better." Another relative we spoke with said, "We call in at odd times and it's always the same – welcoming."

Staff had a good knowledge of people and were able to communicate effectively with them. This meant that they could have meaningful discussions with people about the support they wanted, their plans for the day and their interests. For example, we saw staff engaging with one person using their preferred communication style over the music they wanted to listen to. Staff knew which music they tended to prefer, so worked through a selection of CDs to work out which song the person wanted to listen to. In another example we saw staff encouraging a person to have some breakfast. This involved staff explaining the food options the person could have and reminding them which foods they usually enjoyed. We saw this helped the person to decide what to have for breakfast and that they went on to enjoy it sitting and eating with staff.

Staff told us they enjoyed getting to know the people and they enjoyed spending quality time with them. One member of staff told us, "Our residents that are non-verbal all respond to touch and eye contact and that is great when you see them acknowledge what you have done."

People were encouraged to be as independent as possible. Staff were always on hand to assist or offer support, but tried to encourage people to do as much as they could for themselves. In one example we saw a person enjoying a painting activity assisted by a member of staff. The staff member helped by preparing paint but then gave the brush to the person and advised them on where to paint next. People were free to move around the building as they chose and spend as much or as little time in their own rooms or communal areas as they wished. Staff told us they tried to encourage people to do as much as they could for themselves. One member of staff told us, "We try to assist and not 'do' every time, otherwise whatever capabilities someone had will soon disappear."

People were treated with dignity and respect. Staff spoke with people in a friendly and caring but professional way at all times and addressed people by their preferred names. Staff knocked on people's doors and waited for a response before entering. Where people indicated that they wanted support staff approached them and asked quietly and privately how they could help. Staff we spoke with understood the importance of treating people with respect. One member of staff told us, "There is dignity and respect in everything we do here. Nothing less than that for our residents."

At the time of our inspection two people were using advocates. Advocates help to ensure that people's views and preferences are heard. Advocate visits were documented and the registered manager told us how they were involved in reviews of people's support.

No-one was receiving end of life care at the time of our inspection but the registered manager told us about the procedures in place to arrange this where needed. One member of staff told us, "One of our residents died recently and we all took turns to be with that person as that was part of the end of life request."

Good

Is the service responsive?

Our findings

Care and support was based on people's assessed needs and preferences. Throughout the inspection we saw staff following guidance contained in people's care plans which helped to ensure care was person centred. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. Relatives we spoke with said they were involved in planning people's care.

Before people started using the service they were assessed in a number of areas, including personal hygiene, health, sleeping, life skills, communication and mental capacity. Where a care need was identified a care plan was drawn up based on how people needed and wanted to be supported. For example, one person's personal hygiene care plan contained detail on what they needed help with and what they liked to do for themselves, such as drying their face with guidance from staff. Another person's care plan contained guidance on words and phrases staff should use to help reassure the person when they became anxious or presented with behaviour that challenges. Care plans were written from the perspective of the person they belonged to, which helped to emphasise the person's role in developing them. We saw that care plans were regularly reviewed to ensure they reflected people's current needs and preferences.

Staff were knowledgeable about people's support needs and were able to talk in detail about how they liked to be supported. For example, one member of staff told us, "Each person is bespoke and needs their own routine and special way of doing things and we care about getting it right every time." Another member of staff told us how they had worked hard to ensure a personal care plan reflected a person's preferences. They told us, "[Named person] hates seams on socks. This I have found out and now we all take care to use seamless socks. It is a small thing to us but a massive thing to the resident who cannot put on socks." We saw staff discussing people's support needs with each other throughout our visit, and a communication book was used to handover information to staff working later in the day. One member of staff said, "We share knowledge through the communications book and team meetings, which are very informative." This meant processes were in place to ensure staff had the latest information on people's support needs. Each person also had an assigned key worker, who was the lead member of staff responsible for the person's support. This helped to ensure people received continuity of care.

People were supported to access a range of activities based on their personal interests. Several people who used the service were supported by staff to access a local day centre. There were numerous books, games and activities in the service's communal areas and we saw people using and enjoying these during our visit. Staff used 'daily activity sheets' to monitor the activities people enjoyed to see if they could be offered further support to access them. We saw from these that people were helped to access a range of activities, including listening to music, going out for coffee, arts and crafts, spending time in the garden, dancing to the service's jukebox and going out on bus trips. People's activity interests were also discussed during care plan reviews. We saw that one person had asked for help to arrange and go on a holiday, and records confirmed this had been arranged.

Procedures were in place to investigate and respond to complaints. The provider had a complaints policy, setting out how complaints would be investigated and the timescales for doing so. There was an easy read

version of the policy for people using the service. The registered manager said no complaints had been received since our last inspection but was able to describe how they would be investigated in line with the provider's policy.

Good

Is the service well-led?

Our findings

Staff spoke positively about the culture and values of the service and said they were proud of where they worked. One member of staff said, "It's brilliant knowing you can come here and help the residents and get paid. What a privilege." Another member of staff told us, "We are so lucky we have an amazing team and we are all committed to do our best for the residents." None of the
staff we spoke with said they could think of any improvements that could be made. One member of staff responded, "We are a family here. When the door closes and we are in the resident's home we are all the same, helping each other."

Staff spoke positively about the registered manager and deputy manager. One member of staff we spoke with said, "Our manager is good and approachable and has been here since the place opened." Another member of staff told us, "The deputy manager is an excellent leader and when [the registered manager] is off she is so good to have if we have a problem."

Staff said they were also supported through regular team meetings. Where staff were unable to attend the minutes of meetings were sent to them so they could see what was discussed. Staff also said they could raise issues at any time outside of meetings.

The registered manager carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The registered manager's checks included a daily medicine audit, a weekly finance audit and monthly care plan audits.

Records confirmed that where issues were identified action was taken to address them. For example, a care plan audit in October 2016 identified that one person's needs had changed and the audit found that some up to date information was missing This led to the care plan being passed to the person's keyworker to be updated. The provider also carried out quality assurance checks at the service, including monitoring training levels and organising manager meetings where registered managers from its services could meet and discuss policies, procedures and best practice.

Feedback was sought from people using the service, relatives and external professionals through an annual questionnaire. This was produced in an easy read format for people using the service. The survey had most recently been carried out in 2016, when six people using the service responded. We saw that their responses contained positive feedback on the service, with people saying they were happy with the support provided.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.