Avens Ltd

St Anthony

Inspection report

St Anthony
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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

The inspection took place on 30 and 31 January 2018, the first day was unannounced.

St Anthony's is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can provide accommodation and personal care for 29 people in one adapted building. The service is accommodated over three floors and arranged into three flats, 'Beacon View' accommodated six people; 'Forest View' accommodated six people and 'Tree Tops' accommodated five people. the service also had single studio rooms and flats which people lived in. There were 25 people using the service at the time of the inspection. The service provides support for people who have a learning disability living with some with mobility and sensory needs.

St Anthony's was designed, built and registered before the Care Quality Commission (CQC) 'Registering the Right Support' policy and other best practice guidance was published. 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 other complex needs using the service can live as ordinary a life as any citizen.

The service did not have a registered manager at the time of inspection, but a manager has subsequently been registered. An acting manager was appointed in July 2017 and had begun the process of registering with the Care Quality Commission (CQC) at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last focussed inspection on the 23 February 2017, the service was rated Good overall and was rated Requires Improvement in the 'safe' domain. A breach of legal requirements was found. Following the last inspection, we asked the provider to complete an action plan to show what they would do to meet legal requirements in relation to a new breach of Regulation 12 of the Health and Social Care Act Regulated Activities Regulation 2014, Safe care and treatment. They provided an action plan on 28 April 2017 detailing what they would do and by when to meet the breach. We undertook a comprehensive inspection on 30 and 31 January 2018 to check whether the required action had been taken, improvements made and the breaches met. We found that they had. The overall rating for St Anthony's remains Good. This report discusses our findings in relation to this.

Risks to people had been assessed and there was clear guidance for staff in how to support people. Care plans and risk assessments were comprehensive and provided detailed guidance for staff in how to support people with their needs including; moving and handling, skin integrity, bathing, nutrition and choking. Staff received the training they needed to support people and worked closely with healthcare professionals completing assessments relating to the risks that were managed.

Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar incidents occurring. Risks associated with the environment and emergencies including fire and infection control were identified and managed. People were supported to have their medicine safely when they needed it. The provider had arrangements in place for the safe ordering, administration, storage and disposal of medicines. People were supported to maintain good health and had access to health care services.

People and relatives told us they felt the service was safe. One relative told us, "My relative has been here a long time, we have no concerns about their safety, and it gives us peace of mind." People were protected from the risk of abuse because staff understood how to identify and report it to their managers and the appropriate authority. Staff had completed training and demonstrated they understood the different types of abuse people may experience such as physical and financial abuse. Staff understood the importance of protecting people who were at risk of discrimination and were confident any concerns they raised with the provider would be acted on.

People, relatives and staff told us there were suitable levels of skilled staff available to meet people's needs safely. Staff received an induction and training to ensure they understood how to support people living with complex needs and behaviours that could put them or others at risk. Staff told us they felt well supported through supervision, appraisal and training and could demonstrate how to work with people's complexity of need. Staff received suitable specialist training including; Parkinson's awareness, epilepsy, medicines, Mental Capacity Act 2005 (MCA) and positive behaviour support. The provider ensured that when new staff were employed, safe recruitment practices were followed to ensure they were suitable to work with people.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People's capacity to make decisions had been assessed. People were supported to make choices and take decisions where they could. Staff supported people in the least restrictive way and when required they had access to advocacy services.

People were encouraged and supported to eat and drink well. One person told us, "The food is awesome. If I don't like what's on the menu, they will bring me something else, and the cook will ask me what I want before he cooks it." Special dietary requirements were met. People's weight was monitored with their permission if, for example, they were at risk of weight loss.

Staff were caring and respectful. One person told us, "Yes staff are caring they are there when I need to talk to someone." Care and support provided was personalised and met people's diverse needs. People and their relatives were included in the assessments of their needs and development of care plans.

People's difference, individuality and preferences were respected. People were encouraged to be as independent as possible and had access to meaningful leisure, vocational and community and service based activities that reflected their interests and abilities.

Quality assurance audits completed by the provider were embedded to ensure good levels of quality was maintained. The provider was committed to improving the service through external audits, satisfaction surveys and was active in local forums for providers.

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

Risk assessments supported staff to keep people safe. Risks were identified, assessed and managed. Staff received sufficient guidance and detail to carry out people's care and support needs.

Medicines were administered and managed safely.

People were supported by staff that were trained and understood their responsibilities in relation to protecting people from harm and abuse. Safe recruitment practices were in place.

Is the service effective?

Good

The service was effective

People's care plans and personal spaces were personalised and reflected their individual needs, likes dislikes and preferences.

People were supported by staff that were knowledgeable and received suitable training and support, including specialist training including, positive behaviour support.

Staff had a good understanding of the Mental Capacity Act 2005 and worked towards meeting the requirements of the Deprivation of Liberty Safeguards.

People's nutritional needs were met and their health needs were monitored, reviewed and planned for by staff who communicated well with health professionals.

Is the service caring?

Good

The service was caring

People were supported by kind and caring staff that knew them well and listened to them.

Staff adapted their communication style to meet the needs of the people they supported and encouraged independence.

People were supported to access advocacy services and be involved in the decisions that affected their lives.

People's dignity, diversity and privacy was respected and promoted.

Is the service responsive?

Good

The service was responsive

People were provided care and information in an accessible and personalised way and care plans and records reflected this.

People were supported to access meaningful activities, at home and in the community.

The views of people and their relatives were encouraged to inform changes and improvements in the service. Complaints were managed suitably.

Is the service well-led?

Good

The service was well led

There was an established visible leadership and people, staff and relatives spoke positively of the management of the home.

Staff understood their roles and described an open culture where their views were listened to and acted on.

Effective systems were in place to audit and quality assure the service.

St Anthony

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 checked 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 home, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 30 and 31 January 2018 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked the information that we held about the service and the provider. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the service does well and improvements they plan to make. This included previous inspection ratings and statutory notifications sent to us by the registered manager that tell us about incidents and events that had occurred at the home. A notification is information about important events the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we observed care and support in the communal spaces and people's rooms. We read five people's care records and three medicine administration records. We care pathway tracked people living at the service. This was so we could look at people's care planning in depth and match this with their experiences and our observations. We also read other records which related to the management of the service such as staff files, training records, policies and procedures and quality assurance information. We spoke with eight people who use the service, four care staff, the acting manager, the director of operations, the head of care and the head of another service who was supporting the acting manager and observed how people were supported during the day and with their meals. We also spoke with three relatives, one adult social care professional and a music therapist so that we could further understand their experiences and those of people who could not talk with us. We have included their feedback in the main body of the report.

The last inspection of the home was 23 February 2017 where we found a breach of the Health and Social Care Act 2008 (Regulated activities) 2014. The service remained rated as 'Good' overall and rated Requires

Improvement for the 'safe' domain.

Good

Is the service safe?

Our findings

People said they felt safe and were happy with the care given. One person told us, "Yes, I feel safe and so much better in myself." Relatives told us that they felt people were safe, this was confirmed in relative's annual surveys. One relative told us, "My relative has been here a long time, we have no concerns about their safety, and it gives us peace of mind." Another told us, "They do care for my relative and keep them safe and secure."

At the last inspection in February 2017, the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) 2014. This was because people had not always been protected from the risks associated with their care routines including; moving and handling, skin integrity, bathing and choking while eating or drinking. This was because risks relating to these needs were not robustly managed as care plans and risk assessments lacked sufficient detail and guidance for staff. The provider sent us an action plan on 28 April 2017 explaining what they would do to ensure that they were meeting the regulations by 31 May 2017. At this inspection on 30 and 31 January 2018 we found the provider had made improvements to comply with the legal requirement and the breach of regulation had been met.

Risks to people were managed safely. Each person had an individual care plan that was supported by risk assessments that covered a range of needs, including, moving and handling, skin integrity, bathing, nutrition and choking, the use of bedrails and challenging behaviours. These gave guidance to staff on the level of risk, how it may occur, and how to minimise the risk of restrictive practice.

Moving and handling risk assessments were in place to ensure where people required hoisting to move, transfer or adjust their posture that consistent guidance was in place for staff to do so safely. Staff, care plans and risk assessments described people's moving and handling needs and specific equipment including; the type of hoist, the sling size and the sling loop attachment required to ensure the sling positioning met the person's individual needs. Staff told us they received regular practice based training and worked closely with physiotherapists and their assessments to ensure they could support people safely.

Skin integrity assessments including; Waterlow and pressure area risk assessments were in place and regularly reviewed by health professionals to ensure that risk of people's skin breaking down was regularly assessed and minimised. Guidance was in place for staff to ensure they knew how to manage the risk to people's skin integrity including; the risk of the development of pressure areas due to people's posture and weight loss, and the risk of skin irritation or breakdown due to continence needs not being managed safely. For example, one person with a degenerative condition that effected their posture and weight, had guidance in place detailing the frequency of personal care, repositioning, the correct settings of their air mattress and guidance on when barrier cream should be used to promote skin integrity. Records and staff confirmed the actions detailed in the guidance were understood and completed. Staff told us they received regular information in relation to the degenerative condition through a specialist case worker and worked closely with the district nurse who reviewed the person weekly to ensure they could support the person safely.

People's needs in relation to bathing and other daily risks were assessed and detailed guidance provided.

For example, one person's care plan and bathing risk assessment, detailed that in relation to their epilepsy needs that they should not be left alone when bathing and that staff were required to ensure the water temperature of the bath was suitable. This ensured that staff had clear guidance on what actions they needed to take during these activities and that risks relating to people's safety were mitigated.

At the last inspection some people were at risk of choking and risk assessments were in place that included information and assessments provided by speech and language therapists and dieticians. However, there had not been suitable detail in relation to what staff should look for if people's risk of choking may be increasing, for example, increased coughing during meals. At this inspection care plans and choking risk assessments detailed signs for staff to look out for and what action to take. For example, one person's eating and drinking risk assessment detailed what staff should look out for and contact a GP if they observed, regular refusal of food or drink, distress while eating, increased coughing on food or drinks and regular chest infections. This ensured that staff had suitable guidance available to work preventatively and safely in relation to the risk of choking in relation to people with complex needs who may not be able to communicate any discomfort while eating or drinking.

Environmental risk assessments, audits, and a programme of regular health and safety checks ensured measures were identified to minimise environmental risk. The registered provider had oversight of health and safety through audits and checks of fire safety, LOLER, COSHH, Legionella, gas safety, food hygiene compliance checks and emergency plans. Personal Emergency Evacuation Plans (PEEPs) were in place for people. PEEPs provide information to staff on what action should be taken with people should the service be required to be evacuated in the event of an emergency.

Accident and incident records demonstrated that staff and the registered manager continued to take appropriate action following incidents. Where the incident involved actions of people where they placed themselves or others at risk of harm through challenging behaviours, these were investigated and recorded in more detail through the positive behavioural model. This was done by looking at what happened prior to the incident, during and after, so that risk assessments could be developed, lessons could be learned and care plans adjusted to reduce the likelihood of reoccurrence.

People were protected by the prevention of infection control. Staff had good knowledge in this area and attended regular training in this area. PPE (personal protective equipment) was used when required including aprons and gloves. The provider had detailed policies and procedures in infection control and the environment was clean and free from malodours. The provider had an ongoing schedule of redecoration to ensure the more tired areas of the service were decorated.

We looked at the management of medicines and observed medicines being given safely. One relative told us, "Medicines seem fairly well managed; my relative's seizures are not as numerable as they were." We observed that staff gave medicines respectfully having gained consent from the person, and as described in their support plan. For example, one person took their medicines with yoghurt, this was detailed in their care plan and medicines records and their GPs authorisation had been suitably gained. Clear guidance and systems were in place to ensure the safe storage; auditing, reordering and disposal of medicines took place. Staff that administered medicines were trained and assessed as competent to do so. Where additional training was required, for example when administering Buccal Midazolam, an 'as required' medicine for epilepsy; records and staff confirmed that this had taken place. There were also processes in place to ensure that these medicines were taken safely into the community when the person was outside of the home.

The Medication Administration Record (MAR) sheets demonstrated that medicines were given safely and recently introduced daily checks completed by the team leaders ensured that people received their

medicines as prescribed. Where people took medicines as part of their positive behavioural support plan, clear guidance including; communication tools specifically designed to support staff to recognise nonverbal signs of distress or pain were completed to inform staff under what circumstances this should happen. This ensured that restrictive practices were minimised and that medicines were only administered when required and people's human rights were maintained.

People were protected from the risk of harm. Staff had attended safeguarding training and knew how to recognise abuse and report any concerns they had. Staff received training in equalities and diversity awareness and confirmed they understood the importance of protecting people from all types of discrimination. Staff understood their responsibilities and followed safeguarding policies and procedures to protect people from abuse and were confident any concerns they raised would be taken seriously by managers. One staff member told us, "Yes the managers always take any concerns we have seriously." Staff had access to a whistleblowing policy and procedure and knew how to escalate concerns to the acting manager, director of operations and external agencies when needed. Records showed the acting manager reported concerns to the local authority to ensure people's safety and protect their right to remain safe.

People received support from a sufficient number of staff. One person told us, "There are more than enough staff here." Relatives and staff felt that there was enough staff on duty to safely meet the needs of people and we observed staff had time to respond to people's requests. Staff rotas demonstrated that staffing levels including permanent and bank staff were consistent throughout the day and night. The acting manager and relatives acknowledged that new staff had been recruited recently and that they were still building relationships with people and their relatives. However, staff told us there was always a good balance of experience and skills on each shift and relatives acknowledged that there was a core group of well-established staff who knew people well.

Staff recruitment processes were followed to ensure that new staff were safe to work with people. Staff files included previous work history, detailed application forms including equalities statements, proof of identity, interview records and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to ensure staff were suitable to work with people or children. The DBS is a national agency that keeps records of criminal convictions.

Good

Is the service effective?

Our findings

St Anthony's was designed, built and registered before the CQC policy 'Registering the Right Support' and other best practice guidance was published. One relative told us, "St Anthony's is an important place for people like my relative, the way it's split into flats works very well." The building was large and the acting manager and director of operations were aware that the building's size and décor would benefit from being more personalised to ensure that it was homelier for people living there. Improvements had been made to the environment involving people and families including an ongoing programme of redecoration and refurbishment to the three flats and individual bedrooms. The director of operations told us they were focussed on responding to people's individual needs and making the building more responsive as people's physical needs changed. Two bathrooms had been recently refurbished and adapted to support people with mobility needs and a flat for people who could transition to more independent living had been developed on the top floor of the building. There were a further three flats in the building that were for individual use and these were personalised and homely.

The care and support requirements of people with complex needs were considered and supported by the communal spaces in the individual flats. For example, some people presented behaviours where they may put their own or others wellbeing at risk through throwing objects. To reduce this risk, shared spaces were more sparsely decorated, and some items were secured to the wall, for example a TV set. Each flat had a lounge which was divided into a dining room and TV area and people with similar needs were supported in each flat. People's rooms were very personalised and provided them with space to carry out their preferred activities and privacy. Staff we spoke with told us this supported their emotional and physical wellbeing, for example one person was supported to access a double bed when they expressed an interest in having relationships, another person had a sensory lamp centrally placed in their bedroom to help them relax.

People received care that was responsive to their needs. Initial assessments were undertaken prior to a person moving into the service, then a care plan was produced around the needs of the person. Staff told us how someone recently placed had been supported to visit the service with their family, and chose the individual flat they lived in. People living in the flats were assessed when placed as having similar needs and the communal spaces in the flats were tailored to support these needs.

People and their relatives felt staff listened to them and had the skills and knowledge to support their choices, preferences and care needs effectively. People living at St Anthony's had complex needs and could present behaviours that could challenge and present a risk to themselves and others. One person told us, "Yes, they are always there if I need to speak to them." One relative told us, "The staff that the manager employs are given the training to do the job." Relatives spoke positively about the more established staff. One relative told us, "One of the strengths is that although staff change frequently, my relative's key worker has been here for years." One relative told us there was less rapport built with newer staff. The acting manager and team leaders were aware of this and told us that they were looking at ways to build relationships and that each shift with newer staff included established experienced staff to ensure consistency of practice.

Staff had the appropriate skills and knowledge to support people living in the service. They told us that they had received the provider's mandatory training and induction that included shadowing an experienced staff member who could demonstrate how to work with people's complexity of need. They also told us about more specialised training they had received in Parkinson's awareness, epilepsy medicines, MCA and positive behaviour support. The positive behaviour support training gave guidance on how to work with people with behaviour that could put themselves or others at risk of harm. One staff member told us, "The training was really useful; it taught me it was important to stay one step ahead, to think about what could happen and how to break tasks into small steps for people so they were less frustrated." The provider had a clear strategy on delivering training and provided courses monthly so that training remained current and responsive. New staff were supported to complete the Skills for Care certificate that introduces them to a set of standards that ensures that workers have safe introductory skills and knowledge base.

Staff received regular supervisions and could speak with the acting manager or director of operations if they had any concerns or issues. One staff member told us, "I don't bottle problems up; I tend to say if I need things." Another described how they were supported having made a request to their manager to initially only work in one area of the service so they could learn about the people's needs and develop their confidence, before working in other environments.

Staff demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 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 capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Care Act (MCA) 2005. There were policies in place and staff told us they had completed training, and had access to guidance within peoples care plans about consent, best interest decisions, MCA assessments and DoLS. For example, one person who had a legal representative had suitably authorised specific MCA assessments in place in relation to their day to day decisions, the use of bed rails, accessing a flu vaccination and consent to taking part in a training video of how staff should support them with manual handling.

Staff demonstrated a good understanding of the importance of consent and working towards the principles of the MCA. For example, one staff member told us that every person had the right to make the decisions they could, for some people it was the simple day to day choices such as what they ate and what they wore that needed to be respected. People told us that staff asked for consent before entering their rooms, and we observed staff asking for consent when offering support with personal care and offering activities.

CQC is required by law to monitor the operation of the Deprivation of Liberty Standards (DoLS). DoLS are the process to follow if a person has to be deprived of their liberty in order for them to receive the care and treatment they need. Records showed that DoLS applications had been made for those that lacked capacity.

People's nutritional needs were met. Mealtimes were relaxed and unrushed and people could serve their own portion sizes. We saw that menus were varied and offered fresh fruit and vegetables to encourage healthy eating. One relative told us their relative ate with vigour and, "Doesn't look like they are wasting away." People planned the menu with staff in advance to ensure their preferences were known and there were pictorial menus available in the flat kitchens. Where people did not want what was on the menu they could make snacks in the flat kitchens or an alternative was offered. One person told us, "The food is awesome. If I don't like what's on the menu, they will bring me something else, and the cook will ask me

what I want before he cooks it." Another person who was unable to communicate verbally, was observed as showing their 'contentment' signs and behaviours having eaten their meal, these included, smiles, laughter, pretending to trip over which was a common way this person showed they were happy and content.

People's dietary needs were met. One person had been referred to the Speech and Language Team (SALT). There was a detailed swallowing assessment that identified the consistency of food the person required and other actions to minimise the risk of choking. Staff were knowledgeable of this assessment and we saw guidelines were followed at lunch-time. People's weights were recorded regularly to identify if they were at risk of malnutrition or under nourished.

The service supported people to maintain good health with input from health professionals on a regular basis. People, their relatives and staff told us they had regular contact with learning disability health advisors, SALTs, dentists, physiotherapists, psychologists and GPs. One person told us they had just given up smoking and were using e-cigarettes; they had also registered with a new GP and were visiting their dentist.

The service demonstrated a creative use of technology. The provider was working with one person's physiotherapist with their consent to develop a training video for staff to demonstrate how they could support an individual's moving and handling needs more consistently when they were being hoisted.

Good

Is the service caring?

Our findings

People were cared for by kind and caring staff. Throughout the inspection staff were attentive and respectful and gave people reassurance. People and their relatives were positive about the care provided. One person told us, "Yes staff are caring they are there when I need to talk to someone." Relatives gave examples of how staff were caring. One relative told us, "My relative had problems with their teeth and had an extraction in hospital. Staff slept on the floor next to them when they returned. I never had any doubt they are looked after." Another told us, "Staff do care they keep my relative safe and secure." A volunteer told us, "This is a caring environment, everyone is respectful and professional."

Although people were not always able to communicate verbally, they appeared happy and comfortable with staff, initiating and receiving touch, making good eye contact, smiling and using objects of reference to communicate, make choices and initiate contact with staff. People used humour with staff and were equally as relaxed with the acting manager as other staff. In response to communication needs staff adapted their tone, spoke slowly and responded to questions and known signals in a reassuring and consistent way. We observed visual communication tools being used such as visual menus, weekly care and activity plans and a staff picture board showing who was working in the morning and at night.

Staff told us that they cared for people and demonstrated that they had a good knowledge of people's individual needs, backgrounds, likes, dislikes and preferences. One staff member told us, "The best bit of the job is when I see people happy and smiling." One person showed us their room and was very enthusiastic in their gestures and body language when the staff member asked them about their volunteer role with horses at a local stable. They were keen to share pictures of themselves with the horses that they visited. Staff told us the person had managed to turn an interest into a community activity where they socialised, gained skills and felt a sense of achievement.

Relatives visited the service regularly and told us that they were always welcomed by staff and offered a private space and refreshments. People who could communicate told us they were involved in their initial assessments and reviews. Where family members had the right to be included in reviews they were regularly informed about changes in activities, health or any incidents involving their relative's wellbeing.

Peoples' differences were respected and personal spaces were very personalised to meet individual needs and preferences. People's rooms were very individualised for example people had family photographs, favourite pop star pictures, sensory lights, fish tanks, dolls and objects of reference freely available in their personal spaces. Personal interests and identity were also expressed on the outside of people's rooms. Some people chose to have a picture of their favourite football team; others creatively collaged their door with many things they liked. People wore clothes of their choice and could choose how they spent their time. We observed that people had their meals at different times and had a choice to participate in communal activities or spend time in their own space.

Peoples' independence was encouraged where it could be. A relative told us, "My relative is encouraged to do simple things, make his own drinks, and make a sandwich." One staff member told us one person had

been supported through a significant illness which had left them weak and dependent on staff for many aspects of their care. They spoke proudly of how as their condition and wellbeing improved the service had supported the person to regain their independence. For example, they encouraged the person to build on their strength and confidence in washing themselves. Through supporting them to develop the skills step by step they now able to shower independently.

People were supported to actively express their views and be a part of their support and the service. People met with their key-workers to discuss their care plan and talk about goals or activities they may like to do in the future. One person told us, "I go out buy a newspaper and I can make tea and cereal when I want to." One staff member told us they were working with one person to redecorate their room, and developing colour schemes

Peoples' diversity was respected and promoted within their day to day experiences and care planning. For example, one person was known to like spicy foods as this was part of their and their relatives cultural background. This was noted in their care plan and included in their menu planning. Religious beliefs and how these were expressed were detailed in care plans. People had access to church services in the community and organisations including health professionals that supported young people with decisions they were making about relationships. For example, one person was interested in developing a relationship however the use of social media had previously presented risks to them and others. Staff worked closely with the person and health professionals to ensure the risk associated with the use of social media were reduced through limiting site access and encouraging other forms of contact to meet people.

Peoples' dignity and wellbeing was considered and promoted. When people required assistance from staff they did this in a discreet and sensitive way. We observed staff adjusting their height when speaking to people and offering praise and reassurance when they successfully completed a task. For example, taking their meal plates back to the kitchen. This demonstrated that they were sensitive to people's practical and emotional needs.

Privacy and confidentiality were respected. One person told us, "Staff knock on my door before they come in to my room." We observed staff waiting for consent to be given before entering people's rooms. One person told us they held a key to their room so that they could lock their door to ensure that their privacy was maintained. Privacy, with regards to the information held about people, was promoted and records were stored in locked cabinets in the office.

Where people did not have relatives involved. The registered manager and staff told us that people had advocates or in relation to Deprivation of Liberties safeguards (DoLS) and Relevant Person's Representative (RPR). An RPR is an independent Best Interest Assessor who supports a person for the duration of their DoLS and is able to speak on a person's behalf, when they may not be able to do for themselves.

Good

Is the service responsive?

Our findings

People were supported with personalised care and support plans that responded to their needs. People and their relatives told us they were listened to by staff and involved in making decisions about their care and support needs. Staff told us that they understood people's needs and had positive relationships with them and their relatives. One staff member told us, "It's important the care suits the individual's needs and promotes their wellbeing. We work on people's strengths so they are never bored or sad."

Staff told us that people were involved as much as they could be in developing care plans. They told us that care plans and guidelines were clear and that they built on this knowledge by regularly meeting with people and offering choices. Initial assessments were completed for new people to ensure the service could meet their needs and fully understand how to support their presenting needs and behaviours. One person told us that they and their relative had been involved in care planning. They told us, "I was surprised how much they wanted to talk to me and how much they wanted to know." Transitions between services were planned to match the person's ability to manage change and to support the development of care plans. One staff member gave an example where a recent placement had supported a person to develop their daily living skills to the degree that they were able to become independent enough to move into their own flat within supported housing.

Information for people and their relatives was provided in a way that met people's needs through accessible formats. The provider had pictorial versions or their statement of purpose, complaints process and service welcome packs. Visual communication tools were used for menus and group and individual weekly activity plans, people had visual health action plans and communication passports for any hospital appointments or admissions, to support hospital staff to meet their communication needs. Some people used Makaton sign language to communicate with staff and the use of technology was promoted. For example, one relative told us, "My relative has a tablet device which allows us to send them pictures of the family, it also allows them to make choices in the clothes they want to buy and how they want their room decorated."

People's care and care plans were personalised and reflected their life experiences, likes and dislikes, communication and behavioural needs. For example, one person was unhappy using transport, but enjoyed walking and holidays. Staff arranged for a holiday cottage within walking distance of the service so that the person could enjoy a break while their room was redecorated and pursue their love of walking. Another person's plan noted the importance of staff providing visual examples and providing instructions in small amounts when teaching them new skills so they could process the information and focus on the activity without becoming frustrated.

Individual care and support needs were detailed and guidance given to support staff to provide personal care. Staff could describe moving and handling assessments, including information around specific equipment to be used and how they should encourage the person to aid their mobility. For example, one person required to be hoisted and the care plan detailed how many staff were needed to support the person safely, hoist positioning and guidance on how to carry out the manoeuvre and ensure the person was reassured throughout the procedure, including visual and vocal signs if the person was not comfortable.

People were supported to try new things, develop skills, set goals and increase their levels of independence through reviews and monthly key worker meetings. One relative told us, "We've hit on the music thing they enjoy that." People had opportunities to pursue recreational experiences in their local community including; swimming, massage, gyms and visiting shops and cafés. People also had access to voluntary work within their local community including; local charity shops, stables and a walled garden project. One person worked alongside the maintenance worker carrying out jobs in the service that included testing the fire system and general maintenance.

A plan of individual and group activities was in place and reflected people's personal interests. During the inspection a sound therapist visited. They told us they visited the service twice a week providing one to one and group sessions. These music activities were tailored to people's needs. For example, one person with limited movement and dexterity enjoyed being sung to and participated by playing percussion instruments as they were easy to move and produce a sound from. Another group based session included the use of keyboards and guitars, and the therapist told us how people explored how the different instruments worked and were encouraged to join in and socialise through music events.

When needed end of life care was promoted and choices including funeral arrangements and religious preferences discussed within care planning. For example, one person's plan discussed the music they would like at their funeral and their religious preference.

Good

Is the service well-led?

Our findings

People benefited from an established management structure and told us the service was well led. The acting manager was supported by an experienced manager, the head of care and director of operations all of whom were based at the service. People, their relatives and social care professionals told us the managers were approachable and spoke positively of how the service was managed. One relative told us, "Yes the acting manager runs it very well, we see other residents and they seem happy and content." Another relative told us, "I have a good relationship with the manager, makes it nice that we are a part of it."

Staff also spoke positively about how the service was led. One staff member told us, "The director of operations is very supportive, I don't have to wait if I need anything, they will always answer my questions." Another told us, "The acting manager listens and helps solve our issues." A social care professional gave positive written feedback about the service having recently completed several reviews. They noted, 'This is the forth review I have completed and at each review the families have said the communication with St Anthony's was excellent and that they were happy with their relative's care'.

At the time of our inspection, the acting manager had applied to the Care Quality Commission to be the registered manager for the service. The application for the registration was being processed at the time of the inspection and the acting manager has been registered subsequently. The provider told us during the inspection they had given the acting manager time to consider if they wanted the responsibility of being a registered manager prior to them making their application.

Staff told us there were clear lines of accountability and responsibility through their roles and the embedded management structures. This was demonstrated on the day of the inspection through observations of staff interactions with the management team. Daily handover meetings, electronic messaging, shift plans and management schedules underpinned the day to day service delivery tasks ensuring that staff were supported and individual one to one support needs were met in each area of the service. The service value base was demonstrated by how the management team and the team leaders spoke to and about the people they supported and was reflected in team meeting records. One staff member told us, "The service vision and value base was to be proactive, open, caring and respectful of people and their values." Another told us, "To build on people's independence and happiness."

The acting manager and the Provider Information Return (PIR) told us that the provider was committed to improving the service governance and quality assurance processes: 'Following
our last inspection, we have improved our risk assessments which are now more robust in certain areas. i.e. hoisting. St Anthony had its annual external audit in November 2017. The audit was carried out by following five domains: safe, caring, effective, responsive and well-led. We have received very positive outcome and some improvement recommendations which we are now implementing.'

The director of operations completed monthly quality audits to ensure a good level of quality was maintained and areas of improvement highlighted. We observed audit schedules and reports with action plans for weekly medicines checks, maintenance issues, staff training, environmental risks, equipment,

health and safety incidents and fire safety. These demonstrated that the service analysed trends and themes and designed action plans in response. For example, one audit action promoted that the team leaders should complete daily medicines records checks and these were in place. Another noted that having recently accepted a new placement of a person with an acquired brain injury staff should have awareness training in supporting people with an acquired brain injury. This demonstrated that they monitored and made adjustments to the service to improve systems and develop staff skills.

The provider was committed to keeping up to date with best practice and updates in health and social care and participated in local provider forums to exchange ideas and best practice examples. They were also aware of our revised Key Lines of Enquiries that were introduced from the 1st November 2017. The acting manager and provider understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). The acting manager had submitted notifications to us, in a timely way. This meant we could confirm that appropriate action had been taken. There was a policy in place in relation to the Duty of Candour and the manager was aware of their responsibilities under the Duty of Candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment of people.

The provider encouraged open and transparent culture and was continually looking at improving the culture of the service for example; staff were being encouraged on an ongoing basis to use the local systems of communication and were given opportunities through surveys to feedback about their experiences. Staff fedback that their work was meaningful, that they felt well supported through supervisions and that they felt safe. One staff member told us, "Communication is built around the rapport we build with people." The provider produced an information newsletter for people using the service and their relatives. People and relatives told us that they would discuss any concerns they had with managers and were confident they would be heard. Staff told us that they were involved in planning social events including an orchestra evening where groups and individuals taking part in the sound therapy could contribute to musical event at the service. This ensured that new staff and relatives could develop relationships. Partnerships were promoted with the wider local community through activities and volunteering opportunities, with the local charity shops, a local walled garden project and the Horses Trust.

Management and staff work closely with health professionals such as the local GP's, and health specialists when required. Records and assessments from speech and language therapist, district nursing teams and mental health professionals demonstrated that the provider worked cohesively with these teams. The acting manager told us they worked very closely with all professionals they were in contact with, to ensure people received the correct care and treatment required.

Three satisfaction surveys were completed in 2017, which provided people, relatives and professionals and stakeholders with an opportunity to feedback about the quality of the service provided. The survey outcomes were consistently positive and highlighted that people and their relatives trusted and had confidence in the service. One relative fedback, "We consider we are very lucky with our relative's placement and the care afforded by staff, they are very happy."