Livability

Anvil House

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?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 24 February 2016 and was unannounced.

Anvil House provides accommodation and care for up to seven people with a learning disability and physical disabilities within a large detached property. The service does not provide nursing care. At the time of our inspection there were seven people using the service.

A registered manager was in post at the service. 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.

Staff had a good understanding in how to keep people safe. The service had appropriate systems in place to keep people safe, and staff followed these guidelines when they supported people. People received flexible and responsive care because they were supported by sufficient numbers of staff. There were systems in place to manage medicines and people were supported to take their prescribed medicines safely. The provider had a robust recruitment process in place to protect people from the risk of avoidable harm.

Staff were supported to develop skills and knowledge to meet people's needs. Decisions were made in people's best interests. People were supported to make choices about the care and support their received.

Staff supported people to have food and drink that met their individual needs and preferences. People's health needs were monitored and managed by staff with input from relevant health care professionals.

People were treated with kindness, dignity and respect by staff who knew them well. Staff had developed creative ways to supporting people to communicate their preferences.

Staff supported people to maximise their independence. Support was tailored around people's needs and outlined in person centred care plans. Staff ensured that people had meaningful lives and took part in the daily running of their home.

People's feedback was actively sought. They were involved in residents meetings and were able to influence how the service was run. Complaints were dealt with and responded to positively.

There was an open culture and the manager demonstrated good leadership skills. Staff were enthusiastic about their roles and were able to express their views. The provider had systems in place to check the quality of the service and to make improvements where necessary.

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

There were enough staff with the skills to manage risks and meet people's needs.

Staff knew how to protect people from abuse. Staff knew how to minimise the risk of harm

Systems and procedures for supporting people with their medicines were followed, so people received their medicines as prescribed

Is the service effective?

Good

The service was effective.

People were supported by staff who were appropriately trained to respond to their individual needs.

Appropriate measures were in place to ensure decisions were made in their best interests.

People's nutritional needs were met by staff who understood what support they needed.

People were supported to maintain good health and access health services.

Is the service caring?

Good

The service was caring

People received a caring and personalised service from staff that were knowledgeable about their needs and wishes.

People were supported to communicate their needs and preferences.

People's privacy and dignity was respected.

Is the service responsive?

Outstanding

The service was highly responsive to people's needs.

People received personalised care and support, which was responsive to their changing needs.

People were supported to lead a full and meaningful life. Staff enabled people to take an active part in the daily running of the service. Staff had the skills to support people to communicate their preferences and views about the support they received.

Complaints and concerns were listened to, taken seriously and addressed appropriately.

Is the service well-led?

Good

The service was well led.

The service was run by a committed and passionate registered manager who had a clear vision for the service.

There was an inclusive culture where people were encouraged to voice their opinion.

Staff enjoyed working at the service and felt supported.

The manager and provider were committed to continual improvement at the service.

Anvil House

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.

The inspection took place on 24 February 2016 and was unannounced.

The inspection team consisted of one inspector.

We reviewed the information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

We focused on speaking with people who lived at the service and observing how people were cared for. A significant number of the people at the service had very complex needs and were not able verbally to talk with us, or chose not to, so we used observation to help us understand people's experiences of the care and support they received. We spoke with two family members, four care staff and met with the registered manager.

We looked at a range of documents and written records including care records and medicine charts for people who used the service. We also reviewed records about how the service was managed, including those relating to the employment of staff, complaints, accidents and incidents and quality and safety audits.

Good

Is the service safe?

Our findings

People were safe at the service. We observed people felt at ease when staff supported them, for example they approached staff when they wanted a snack or were feeling anxious. A family member told us, "It's difficult to put your trust in people when your family member needs so much support but we have no hesitation in leaving [person] there."

Staff and management understood the importance of protecting people and keeping them safe. Staff were able to describe different forms of abuse and knew what to do if they felt a person was not safe. Where people were assessed as being vulnerable to abuse there was detailed guidance in place. Staff were able to describe how they might recognise possible abuse where people were not able to communicate verbally, for example through observing changes in behaviour or mood. The management of the service was committed to promoting openness and learning from safeguarding incidents. The service notified the local authority appropriately about safeguarding concerns.

Staff knew how to manage risks to people's safety. Risk was minimised through detailed assessments and plans which were tailored to each person's needs. For example, risk assessments were in place where people were supported to use a hoist when they were having a bath or where staff were supporting people to take an active part in daily chores, such as moping the floor. Staff had to sign to say they had read every risk assessment and each assessment had a review date in place. There were processes in place to keep people safe in the event of an emergency, should an unexpected event such as a fire occur. Staff understood what they should do in emergency situations and each person had in place a detailed and personalised emergency plan.

There were enough skilled staff to support people and meet their needs. The manager had a detailed awareness of people's needs and ensured that there was sufficient staffing, including where people needed one to one support. We were given examples of where staffing levels had changed when a person's health needs had deteriorated. We saw records of a staff meeting where the manager had asked staff to be aware of what their colleagues were doing at any point, for example when deciding whether to leave a room. The focus was not on numbers of staff on duty but on ensuring staff had the capacity to meet people's needs. We observed that where people had been risk assessed as not being safe to be left alone, there was sufficient staff in place to keep them safe.

Where the manager needed to employ agency staff, for example to cover long term absence, they brought in the agency staff for a longer period of time so they could get to know people or used staff who had worked previously at the service. We observed that the temporary staff were an integral part of the wider team. This provided continuity of support to people, one family member fed back that, "There are constant carers, not different people popping in and out."

The provider had a safe system in place for the recruitment and selection of staff. Staff recruited had the right skills and experience to work at the service. Staff told us that they had only started working at the service once all the relevant checks had been completed. We looked at recruitment files for three staff and

saw that references and criminal records checks had been undertaken and the organisation's recruitment processes had been followed.

People received their medicines safely and as prescribed from appropriately trained staff. Records of people's medicines were completed appropriately and we noted that they were accurate and legible. Staff communicated well when giving people their medicines. When people had been prescribed medicines on an as required basis, for example for pain relief, there were protocols in place for staff to follow so that they understood when a person may require this medicine. Should a person require urgent admission to hospital, there were "grab sheets" in place to advise hospital staff of their prescribed medicines.

There was a personalised protocol for each person for staff to refer to if they refused to take their medicines. The impact of the person choosing not to take each medicine was risk assessed and an appropriate response outlined. For example, in the case of some medicines, staff were to contact the GP urgently whilst for other medicines where the risk was lower, guidance was in place and people were offered the choice of taking the medicine at a later stage.

We observed medication being administered and the staff member told us they had only started administering medicines after receiving training. In addition, staff had received up to date medicine training and had completed competency assessments to evidence they had the skills needed to administer medicines safely. Processes were in place which took into account the specific needs of the people at the service. For example, to minimise the risk of staff and people being distracted and to maintain dignity, medicine was administered in private. Staff had on-going observations to monitor their skills in administering medicines. Regular medicine audits were completed to check that medicines were obtained, stored, administered and disposed of appropriately.

Good

Is the service effective?

Our findings

People were cared for by staff with the skills to meet their needs and understand what their preferences were. Staff were positive about the training they received. One member of staff told us, "The training here is second to none, there is a lot of training, mainly hands on, with very little e-learning." We saw that the manager had systems in place to track people's training to ensure that people developed skills needed to meet people's needs. Separate arrangements were made for staff who could not attend any training days. Where people's needs changed, training was arranged to provide staff with new skills, as necessary.

The manager supported staff to carry out their duties effectively. Staff told us they were well supported and received regular supervision and annual appraisals. A supervision is a one to one meeting between a member of staff and their supervisor. Staff were supported to continually develop their skills. The manager gave us an example where a member of staff had used a specific word which gave a negative impression of a person. The manager had suggested a better way of describing the person's needs and used this as a learning exercise for the member of staff. Where the manager felt staff had not followed guidance they met with the member of staff to review the incident and address any concerns. The manager and senior members of care staff carried out observations of staff practice and these were used as an opportunity to develop skills. One member of staff was given advice on how to, "Allow [person] time to digest information before giving further prompts."

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. Decisions were made in people's best interest, with staff involving family and outside professionals as appropriate. Staff had received effective training to help them understand the Mental Capacity Act (MCA) 2005 and DoLS legislation and guidance, and were able to demonstrate how they applied the principles of the act in their daily practice. For example, they were able to tell us how they supported people to make everyday choices such as what to wear and what they would like to eat. We observed that staff sought peoples' consent before providing care. The registered manager had completed personalised capacity assessments relating to a wide range of support tasks and activities, for example where there were assessments in place where staff needed support with their finances.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People who could not make decisions for themselves were protected. The manager had made the necessary Deprivation of Liberty Safeguard (DoLS) applications for people living at the home. For example, applications had been

made for to people requiring constant supervision. The manager had notified CQC, as required, of all the DoLS applications which had been made. Restrictions were kept to a minimum but where necessary these were in place to keep people safe, such as a locked door to the kitchen. The manager had reviewed the locks recently but assessed that to remove the locks would place people at too high a risk. We noted however that due to the level of support at the service, people were not restricted from coming in to the unit to prepare food with staff support.

People were supported to have a balanced and healthy diet. There was a focus on promoting a varied diet. We observed that people ate when they wished and were offered a choice of what to eat. They were actively involved in preparing meals where possible. When everyone at the service ate a meal together, food was put into large serving bowls, rather than served on plates, to encourage choice and independence. Where a person had a specific health need relating to nutrition, staff had received relevant training. For example, staff were trained to recognise the importance of nutrition and foot care for people with diabetes.

A number of measurements were taken to enable staff to monitor people's on-going needs, as appropriate. For example, staff weighed people regularly and measured blood glucose levels. Staff supported people to change their diet as appropriate in response to these checks. For example, we heard a discussion on introducing full fat milk into the diet of a person who was losing weight.

Staff supported people to access health appointments and were actively involved in advocating for people by communicating on their behalf to health and social care professionals. People had active health plans in place and were supported to go for regular check-ups, for example to the opticians. We noted that staff were diligent in seeking health input in response to any changes in people's health. Where a person became regularly ill with the same condition, staff had spoken to the GP for advice on signs on how to pro-actively recognise and prevent any deterioration in the person's health. People with communication needs had been referred to a speech and language therapist for support and guidance. As a result, staff had increased the use of photographs as a method of communicating with one person.

Good

Is the service caring?

Our findings

Staff had compassion for people and treated them with kindness. A family member told us, "We are happy to know he is settled there, it's a super service." A member of staff told us, "It's a lovely team; we have time to do things for people." We observed that people had been given the time to develop trusting relationships with staff. We could see that they approached staff with an assurance and confidence that they would be treated with kindness and patience.

Staff were able to describe in detail the people they cared for. Staff told us the manager emphasised the importance of getting to know people before they started providing support on their own, through reading care plans and shadowing other staff. They supported people in a holistic way and often support extended to members of people's families. For example, staff had supported people's relatives during difficult times.

Staff understood the importance of giving people choice. To support this, staff focussed on communicating in an appropriate and clear manner. We observed a discussion around the use of a language, during which staff realised that they all described hoovering and vacuuming differently. The manager emphasised the need for staff to communicate consistently with people. They told staff, "It's easier for us to learn one way of saying things than for people to learn our 10 different ways."

Staff had developed individual methods of communication for each person. We saw one person had a communication book which was used to support them and enable staff to know what they were doing each day. Kitchen doors had pictures on them to assist people with remembering where to find things. Where possible, documents relating to the service were in easy to understand language and had relevant pictures which people could understand. For example, a guidance document about treating people with dignity had a picture of a member of staff knocking on a bedroom. Another picture showed a person being offered the choice of a cake or an apple, which was the preferred method of offering choice to the majority of the people at the service.

People's dignity was supported in a holistic way and attempts were made to promote a homely environment. For example, the manager said that, following infection control training, they had reviewed the controls in place at the service, but discarded some possible measures such as putting soap and paper towels in each bedroom as they felt this was too institutional. People's care plans had detailed step-by-step guidance about how to maintain their dignity during personal care. We observed a commitment to treating people with respect in the way staff interacted with them. A member of staff told us that, "Everything at the service is about dignity and respect."

Referrals were made to advocacy services when required and we saw examples of this in people's care records. Advocacy services were available for people who may need support from an independent person to speak on their behalf.

Outstanding ☆

Is the service responsive?

Our findings

People were observed as having a sense of belonging and to treat the service as their own home. The service was tailored to the needs of the people and the staff took on an enabling role. A family member told us, "The service is excellent, one of the best things that ever happened to my family member." One person showed us a book with pictures outlining the activities they took part in. The pictures portrayed a varied and full week, including domestic chores, social outings and meaningful routines. The person demonstrated through their facial expressions that they were positive about what they did. A staff member also talked us through the book and knew in detail what each picture represented.

The manager had introduced a model of care called "active support" which enabled people to be fully involved in all aspects of their lives. A member of staff told us how it worked in practice, "It feels like home, one person will hoover, and then another will mop the floor. Everyone has their jobs in the morning; it gives them a sense of purpose and teaches life skills." This model was emphasised at every opportunity, for example we noted at a team meeting the manager gave examples where staff should encourage people to do things for themselves. The team discussed how they could divide tasks, such as preparing a drink, into stages so that a person with complex needs could be supported to aim toward achieving one of the stages, such as taking a mug out of the cupboard. Each person had a set of targets, for example, one person's target was to draw the curtains each morning. Where they could not do this independently, clear guidance was given to staff on the level of support to be given to maximise independence, for example "hand on hand" support or verbal prompting. Once the targets were achieved, there were new targets so that the person was always developing their skills.

We observed staff putting the active support model into practice throughout the day. For example, when administering medicines, the member of staff said to a person, "We need a teaspoon, will you come with me to get it?" This demonstrated a commitment to involving people at every stage and maximising opportunities for increasing independence. A high level of skill was required to enable people to engage fully. We noted that staff had been supported to develop these skills, for example they followed guidance in the care plans about using simple direct language when encouraging people to take part in tasks and activities.

Although there was a focus on the model of "active support" throughout the service, the manager emphasised the need to see the person as a whole, not just a series of targets. When discussing how to encourage people to be involved in tasks, the manager said they tried to, "Be kind and be fun." Through observation staff helped people select tasks they could fulfil based on their interests and preferences. Staff gave an example where the person who liked sensory activities had the job of steaming the kitchen floor.

People's care and support was planned proactively and in partnership with them. Staff were observed to offer people choice, for example a person was shown different food choices in the kitchen and by touching the one they wanted, the staff we able to establish their preference. A family member told us that staff knew their relatives needs through the gestures they made. We saw examples in care plans of photos which demonstrated how staff had found out about people's preferences. For example, staff supported people to

try four different pieces of fruit and had documented and photographed their responses, adapting care plans and food choices accordingly.

People's care plans provided detailed and personalised information to enable staff to support people in ways they preferred. Staff members were able to describe in detail people's history and their physical, emotional and social needs. Each person had a named member of staff who monitored their on-going needs and reported monthly, or sooner if necessary, on any changes and risks to ensure that information remained current. One member of staff told us that where routine was important to people, staff were challenged by the manager if support was provided out of sequence. For example, a member of staff explained, "With [person] you help them brush their teeth before getting dressed. It has to be in that order or they become distressed." Care plans were regularly reviewed and people's views taken into consideration. Families confirmed that they were invited to reviews. One family member said, "We've just had a review, I found it helpful but if there were any problems I would ring straight away."

The manager told us that they had worked with staff to develop a service where people had power over the support they received. We found that this was demonstrated throughout the service. Whilst the service had developed from a Christian tradition, staff focused on enabling people to make their own choices in relation to spiritual matters. For example, some people attended church and had developed positive relationships within that community, whilst other people chose not to attend. Decisions over spiritual matters were personalised, for example, people attended a church their choosing and as a result people attended a variety of places of worship. Staff empowered people to have as much independence as possible. Therefore, one person had a raised chair, which enabled them to stand up independently. Staff had realised that this adaptation could also be applied to the taxi, and now carried a cushion with them when they went on trips so that the person could get out of the taxi independently.

The manager responded flexibly to people's changing needs, for example as people's needs deteriorated and more staff were employed, a conservatory was added to provide more communal space. The garden had been adapted to meet the needs of the people at the service. Plants had been selected for their sensory benefits and the manager told us that they had put a great deal of effort into selecting a water feature which was safe but also stimulating. There was also a summer house in the garden which had a dart board and clocks as chosen by people living at the service. Where there were activities and ornaments in the communal areas of the service that enhanced the quality of life for people at the service. For example, there was a harp which people could strum as they moved between two communal living areas. We were told that people liked music and frequently used the karaoke machine at the service.

Staff ensured people were involved in meaningful activities outside their home. When staff took people shopping, they considered what shop the person preferred and would offer them an enhanced experience. So for example, a person who benefitted from a sensory experience would be supported to visit a perfumes and cosmetics shop. Another person who benefitted from experiences based on their sense of touch had enjoyed going to a material shop. When the person spent a long period of time touching one particular cushion it was purchased and used as inspiration when selecting the décor of the person's room.

People were supported to keep in touch with their families and families told us they felt welcome to visit at any time. A family member told us, "It's his place and he's happy for us to go and enjoy his home." Links with the local community were promoted, for example, people had developed links from visiting a pub on the same day of the week. A person's notes said, "I go to lunch at [place]. I have quite a few friends there so this is an important part of my routine."

The provider had a clear policy in place for responding to concerns and complaints. Complaints mainly

stemmed from informal discussions with family members parents and were resolved in an informal, positive way. Family members told us they would speak with staff if they had any concerns. The manager gave us an example of where a complaint had been received and the immediate actions they had taken to resolve the concerns raised.

Most of the people using the service were unable to communicate verbally however staff had developed innovative and comprehensive ways of capturing on-going feedback in ways that made a tangible difference to people's quality of life. People demonstrated their preferences through their actions and staff were skilled at understanding what their preferences were. For example, staff had creatively involved people in deciding what garden activity should be purchased. Staff set up a number of different sensory activities on a particular day in the garden, for example with balls and water. They then observed people's responses, taking photographs as appropriate to help understand peoples' preferences. When one of the people had refused to get involved in the feedback session, staff had monitored what they enjoyed doing over a period of time so that their views were also taken into account. Staff were able to demonstrate that the majority of people had a preference for water and as a result, a sensory water table was purchased for the garden.

Good

Is the service well-led?

Our findings

Family members were positive about the quality of care provided by the service. One relative said, "There is nothing that I can think that would improve the service." One worker said, "I love working here. I'm so happy here, it's not about profit and money, the care is lovely."

The culture of the service was open and enabling. Staff told us they enjoyed working at the service and were encouraged to develop their careers within the organisation. Staff said they were encouraged to make suggestions to the manager about how to improve the service. For example, one member of staff told us the manager had been open when they had proposed a different way of supporting a person who was very anxious. The manager was enthusiastic about promoting people's voice. They spoke with passion about building on the success of recent residents' meetings to continually develop more creative ways of capturing people's opinions, especially where people could not communicate verbally.

The manager was a visible presence and demonstrated effective leadership skills. They were involved in the day to day running of the service and knew the needs of people and staff in detail. For example, we observed them remind a member of staff about a person's needs as they were getting ready to go out for the day. The manager promoted a sense of wellbeing and fun throughout the service. For example, we saw notes in the staff meeting notes which advised staff, "If you have a celebration meals on your shift please make it lavish, like a banquet." The manager tried to make staff meetings enjoyable as well as informative; by running quizzes with small gifts for the winning member of staff.

The manager was pro-active and made changes when necessary. They ensured that where mistakes had happened the service had made the necessary improvements. For example, following an error in medicine administration, processes had been reviewed and staff now took one set of records out of the cupboard at one time. This limited the possibility of medicines becoming mixed up.

The manager was positively supported by the wider organisation, for example a separate department carried out staff recruitment. This meant they had more time to dedicate to developing the service and to developing relationships with staff, professional, people and their families. A health and social care professional told us that that the manager and provider of the service worked positively with them.

The provider was committed to promoting good practice, rewarding the manager when they had introduced new measures and improvements. The provider published a newsletter which promoted best practice, such as the "active support" model of care in place at the service. The manager demonstrated a commitment to continually improving their practice. For example, they attended local forums, using these as an opportunity to develop best practice and promote links with other services.

Effective quality assurance systems were in place to identify areas for improvement and ensure identified concerns were dealt with. Audits were carried out by the registered manager and senior managers from the wider organisation. Plans were put in place outlining the actions needed to achieve required improvements. Senior managers monitored the service against the agreed actions to ensure these were being carried out.

For example, we saw that the service's improvement plan highlighted the need to improve how people's weights were measured. Notes from a subsequent meeting showed an informative and practical discussion had taken place to ensure staff used the weighing equipment correctly. The senior manager had updated the action plan when they had assured themselves that there had been the necessary improvements. There were also audits in place to ensure the manager had notified the Care Quality Commission and Safeguarding Authorities of key information as required.

The manager used innovative solutions to complex problems. A recent audit had highlighted that staff did not always understand how the Mental Capacity Act worked in practice. In response, the manager had written an entertaining story to help staff and people using the service understand the principles of the legislation. We felt this demonstrated an commitment by the manager to promote understanding of a complex subject and to ensure that people's rights under this act were protected and upheld.