St Anne's Community Services

St Anne's Community Services - Calderdale Supported Living

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

At the last inspection on 5 January 2016 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The inspection of Calderdale Supported Living took place on 25 April 2018 and was announced. This was to ensure there would be someone at the property to greet us as people attended community activities on a regular basis.

The service provides personal care and support for people with learning disabilities who may also be on the autism spectrum. There were five people living in adjoining houses, two were in one and three in the other. People lived in tenancies agreed with the housing provider. The accommodation is split into two houses that connect through the office. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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

People told us they felt safe. Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence. Robust emergency plans were in place in the event of a fire or the need to evacuate the building.

A system was in place to ensure medicines were managed in a safe way for people and staff had a good understanding of how to safeguard adults from abuse.

Sufficient staff were on duty to provide a good level of interaction and safe recruitment and selection processes were in place.

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

Staff told us they felt supported and records showed they had received an induction, role specific training and regular supervision and appraisal to fulfil their role effectively.

People's nutritional needs were met, healthy eating was promoted and people were supported to access a range of health professionals to maintain their health and well-being.

The service worked in partnership with community professionals and used good practice guidance to ensure staff had the information they needed to provide good quality care.

Staff were caring and supported people in a way that maintained their dignity, privacy and diverse needs. Observation of the staff showed they knew people well and could anticipate their needs.

People were supported to be as independent as possible throughout their daily lives and individual needs were assessed and met through the development of detailed personalised care plans which considered people's equality and diversity needs and preferences. People worked toward individual goals and we saw these were often achieved.

People had access to social and leisure activities in line with their preferences and interests.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time.

The registered provider had an effective system of governance in place and the registered manager had an overview of the service and knew people's needs well.

People who used the service and their relatives were asked for their views about the service and these were acted on. Information and good practice was shared within and across teams by the registered manager and the registered provider.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

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

This inspection took place on 25 April 2018 and was announced. The inspection was conducted by two adult social care inspectors.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, feedback from the local authority safeguarding team and commissioners. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan the inspection.

Some people who used the service communicated using non-verbal, as well as verbal communication methods. As we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent time observing the support people received. We spoke with two people who used the service and one of their relatives. We spoke with two support workers, the deputy manager and the registered manager. We looked in the bedrooms of three people who used the service with permission.

During our inspection we spent time looking at three people's care and support records. We also looked at two records relating to staff supervision, recruitment and training, incident records, management

information and a selection of audits.

Good

Is the service safe?

Our findings

People and the relative we spoke with told us the service was safe. Staff we spoke with knew how to ensure people were safeguarded against abuse and the procedure to follow to report any incidents. They were able to describe the signs to look out for which would indicate a person was being abused. The service had dealt with some complex safeguarding issues and protected people's autonomy and human rights.

Risks to individual people were documented and staff understood how to support people whilst enabling them and encouraging them to keep themselves safe. Risk assessments were detailed and contained clear directions for staff to ensure risk was managed well and included the positive benefits of the right to take risks. The records we saw included comprehensive risk assessments in areas such as positive behavioural support, choking, road safety, finances, appropriate relationships, medicines and additional person specific assessments, for example; for a specific health condition.

Individual positive behavioural support checklists, to prevent and avoid behavioural incidents, supported staff to reduce risks to people. Risk assessments and care plans also contained information about how staff would care for people when they experienced behaviours that may challenge others and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

Fire safety measures were in place, and people had personal emergency evacuation plans in place. Regular fire drills were held and people were aware of the procedure to follow.

We reviewed the staff rota which showed sufficient numbers of staff were deployed to support people safely. Each person had been assessed for the number of hours they required support and the registered provider facilitated this. The registered provider had their own bank of staff to cover for absence and asked familiar staff to do extra shifts in the event of sickness, as well as occasionally using agency staff. This meant people were normally supported by staff who knew them well.

We looked at three staff files and found safe recruitment practices had been followed.

All staff had been trained to manage people's medicines safely and completed regular medicines competence assessment. Medicines were stored and administered in line with good practice.

Each person had a detailed medicines care plan including photographs of medicines and details of how people liked to take them, including for 'as required' medicines. This meant people were protected against the risks associated with medicines because the provider had appropriate arrangements in place.

Medicines counts were completed twice daily by staff and we found one administrative error during our inspection, which was rectified immediately. Full medicines audits took place every week and checks were also completed by the area manager on some of their visits.

The service was clean and fresh and night staff completed cleaning tasks in communal areas. People were supported to clean their own rooms and there was a good supply of personal protective equipment for staff.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. Staff were aware of any escalating concerns and took appropriate action, with any lessons learned translated into care plans. A log of any accidents or incidents was recorded using the registered providers online system to look for patterns and promote learning from accidents and incidents. This meant the registered provider was keeping an overview of the safety of the service.

Good

Is the service effective?

Our findings

People told us they were able to choose what they ate. One person told us they liked to have their own money to purchase the treats they enjoyed.

Physical, mental health and social needs had been assessed and care plans included guidance and information to provide direction for staff and ensure care was provided in line with current good practice guidance. Assistive technology had been used to support some people to access their locked bedroom independently and this was currently being re-evaluated to improve its effectiveness.

Staff were provided with an induction, training, supervision and appraisal to ensure they were able to meet people's needs effectively. Staff new to care, who did not have equivalent qualifications, also completed the Care Certificate, which is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. This demonstrated new employees were supported in their role.

We looked at the training records for two staff and saw training included infection prevention and control, emergency first aid, food hygiene, moving and handling, equality and diversity, the Mental Capacity Act and Deprivation of Liberty Safeguards, safeguarding adults and positive behavioural support. Optional further training was also available in mental health, autism, pressure care and dementia awareness, which some staff had chosen to undertake. We saw from the training matrix most mandatory training was up to date and further training was planned onto the rota.

Staff competence was also assessed in areas such as moving and handling and medicines management. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

Staff we spoke with told us they felt appropriately supported by managers and had regular supervision and an annual appraisal and we saw from records this was the case. One staff member said, "Supervision is a good opportunity to get things off your chest. I feel listened to." Regular supervision of staff is essential to ensure people are provided with the highest standard of care.

Meals were planned around the tastes and preferences of people who used the service and staff cooked the main meal of the day. People decided what to eat each week at the tenants meeting, using a visual food chart with photographs of meals, which included samples of spices and herbs to smell, for a person who was visually impaired, to support their choice. Each person had a personal place mat for meal times, with information about their dietary support requirements and any risks to ensure all staff had immediate access to this information during mealtimes.

We saw the individual dietary requirements of people were catered for and healthy eating was promoted. A range of healthy recipe cards, with photographs, were available in the kitchen to support healthy choices. One person attended a weekly cookery course and liked to take part in preparing meals in their home.

Details of the meals eaten were recorded in people's daily records. People were weighed monthly to keep an overview of any changes in their weight and action had been taken if weight had declined. This showed the service ensured people's nutritional needs were monitored and action taken if required.

The service had good relationships with community health services and we saw the advice of professionals was included in people's care plans and used to achieve best practice and help people to achieve good outcomes. The service was proactive in identifying people's health needs and had supported people with complex and serious health conditions both physically and emotionally. One relative told us they were generally happy with their relatives health and wellbeing, but would like to be informed sooner of any changes in behaviour.

Health monitoring, such as blood pressure monitoring had been introduced at the service to pick up health problem before they became serious in people who may be unable to fully communicate their feelings of ill health. This had proved effective in flagging up issues. The registered manager was improving the monitoring charts to include more individualised guidance.

Records showed people had access to external health professionals and we saw this had included GP's, psychiatrists, community nurses, chiropodists, dentists, speech and language therapists, physiotherapists and district nurses. People also had an up to date hospital passport in their care records to share information when going into hospital. This showed people received additional support when required for meeting their care and treatment needs.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For this type of service any applications to deprive a person of their liberty must be made to the Court of Protection. Applications had been made for all people using the service and were awaiting assessment.

We found people usually had their capacity assessed where required in order to determine their ability to provide lawful consent. Mental capacity assessments and best interest decisions were completed in areas such as medical interventions, deciding to live at the service and consent to relationships. Whilst mental capacity had been assessed to consent to the care plan, specific mental capacity assessments had not been recorded in relation to medicines and the registered manager told us they would complete this straight away. People's involvement in all decisions and best interest discussions if required was evidenced throughout all documentation. The registered manager and staff members we spoke with had a good understanding of the Mental Capacity Act and it was clear from observations and records people's autonomy, choices and human rights were promoted.

Good

Is the service caring?

Our findings

We asked relatives if they thought staff were caring. One relative said, "[My relative] likes all the staff and has genuine affection for them."

Positive caring relationships were developed through staff understanding people's needs and their personalities. It was clear from our discussion with staff they knew all about the people they supported.

People told us they liked the staff and we observed warm and positive interactions between them. Staff we spoke with enjoyed supporting people who used the service. One staff member said, "Even if it's been a difficult week I reflect on how good the resident's lives have been. We provide a home. I am happy working here."

People were supported to make choices and decisions about their daily lives and care records evidenced this. People told us they had a choice of meals, what time to get up or go to bed, clothing, activities or when to have a bath or shower.

Staff understood how to communicate with people and information was presented in easy read formats to promote good communication. Staff used speech, gestures, photographs, objects of reference and facial expressions to support people to make choices according to their communication needs. Care plans contained details of how to recognise when a person was unhappy or happy using non-verbal cues, including indications when they may be in pain or unwell and the steps to take to improve their wellbeing.

Staff new how to maintain people's dignity, for example when supporting people with personal grooming tasks. Staff gently prompted people, for example; discreetly and respectfully suggesting a person cover their mouth whilst coughing during lunch. The registered manager told us all staff who worked in the service were dignity champions, having undertaken specific training in this area. "What dignity means to me," was recorded in each person's care plan.

People appeared very well groomed and looked cared for, choosing clothing and accessories in keeping with their personal style. People's individual rooms were personalised to their taste with furniture, personal items, photographs, sensory items and bedding they had chosen.

Technology had been used to enable people to maintain their privacy, with a finger print recognition locking system on individual bedroom doors, although this was being reviewed to ensure it was suitable to meet people's level of need.

People were encouraged to do things for themselves in their daily life. We saw from records they were encouraged to take part in food shopping, laundry, cleaning their own rooms and helping prepare snacks. Care plans detailed what people could do for themselves and areas where they might need support for example, "[name] can dress self but unable to manager buttons." This showed us the home had an enabling ethos which tried to encourage and promote people's choice and independence.

People's diverse needs were catered for and equality was promoted within the service. Staff understood how to reduce the barriers for people with physical or sensory impairments, for example; supporting a person with a visual impairment to use their sense of smell to support their choice of meals. We saw from care plans people were supported with their sexuality needs, with clear care plans and mental capacity assessments in place to support people's protected characteristics and to ensure their privacy and human rights were supported. The manager told us they employed an ethnically diverse team and staff knew how to support the cultural needs of people from different ethnic and religious backgrounds.

Staff supported people to see their families and friends as often as desired. This meant people were supported to develop positive relationships and to maintain contact with people who were important to them.

Staff were aware of how to access advocacy services and two people at the service had an Independent Mental Capacity Advocate. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

Good

Is the service responsive?

Our findings

People told us they were supported to make decisions about their daily life and were consulted on every aspect of their support.

We looked at three people's care plans. We found care plans were person-centred and explained how people liked to be supported, for example, "What do I like doing?" "Football, church, singing, balloons." This was important as some people who used the service were not always able to communicate their preferences. Staff were able to tell us details about individual's care and support needs, as well as information about people's personal preferences and lives before coming to live at the service

Care plans contained detailed information covering areas such as health needs, healthy living, emotional support, daily tasks, social support, positive contribution, independence and choice, medication, finances and communication. Care plans specific to people's health conditions were also completed and contained information and guidance for staff.

People and their representatives were involved in regular person-centred planning reviews. Objectives were set with people and these were reviewed and updated regularly, or when needs changed. One person's objectives were, "To go on the train or bus. Go to concerts. Football or rugby matches." There were photos in the care plan showing when the person had achieved their goals, for example, a photo of a show the person had been to. These reviews helped monitor whether care plans were up to date and reflected people's current needs so any necessary actions could be identified at an early stage.

Daily records were kept, detailing what activities the person had undertaken, support provided, choices given, meals eaten, the persons mood and any independent living tasks completed.

The service promoted people's individual wellbeing through innovative person-centred care planning. For example, one person was anxious about attending chiropody appointments and had been prescribed an 'as required' relaxant medicine to support them to attend. To reduce the need for this medicine familiar staff now filed the person nails regularly, which did not cause them anxiety, and they no longer needed to attend the chiropodist or to use the related medication.

We saw staff were responsive to people's needs, asking them questions about what they wanted to do and planning future activities. Staff were patient with people and listened to their responses. This meant the choices of people who used the service were respected.

We saw people were supported to take part in a range of activities, such as attended a local spa pool and rebound therapy sessions, theatre trips, bowling, swimming, and day trips, as well as going out for meals or for a coffee in a local café. One person went to the Yorkshire Show for their birthday and some people chose to attend the local church. On the day of our inspection one person had their regular sensory relaxation and foot spa session in their room, a second person enjoyed doing a jigsaw and some people went out to attend activities in the community.

The registered manager was aware of the requirements of the Accessible Information Standard. This requires the service to ask, record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. We found detailed information regarding people's communication needs and the communication needs of their relatives, where appropriate, was recorded in care plans.

Staff we spoke with said if a person wished to make a complaint they would facilitate this and there was an easy read complaints procedure in people's care records. We saw complaints or concerns had been recorded when they arose, thoroughly investigated and responded to appropriately. The registered manager was clear about their responsibilities to respond to and investigate any concerns received and demonstrated learning from complaints was implemented to improve the service.

Some people and their relatives had discussed preferences and choices for their end of life care including in relation to their spiritual and cultural needs and this was clearly recorded in an accessible care plan. This meant people's end of life wishes were recorded to provide direction for staff and ensure people's wishes were respected.

Good

Is the service well-led?

Our findings

A registered manager was in post. 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.

A new deputy manager was also in post and was being supported with a management development course. Staff told us they felt supported by the registered manager and senior staff, who acted on their concerns. One staff member said, "If I felt the need I could talk to senior managers about concerns, but I have never felt the need here."

Staff we spoke with were clear about the organisations core principles of person-centred care, quality and equality and diversity. The registered manager told us the aim of the service was to promote dignity and inclusion and we saw during our inspection these aims were being achieved.

The registered manager promoted dignity at the service through appointing and training dignity champion and ensuring dignity was embedded within staff practice and records. They attended a dignity network, which met every three months and held a number of dignity themed events every year.

The registered manager said they operated an 'open door policy' and people were able to speak to them at any time and we saw tenants were able to access the office to speak with them or other staff. The management team were visible in the home and regularly worked with staff providing support to people who lived there, which meant they had an in-depth knowledge of the needs and preferences of the people they supported.

The home held coffee afternoons along with other houses, so people could maintain old friendships and make new ones. Parties were held on special occasions throughout the year, such as a Halloween hoedown. People were supported to use local community facilities, such as the library, local chemist and shops to promote good community relationships and networks.

Effective systems were in place to assess, monitor and improve the quality and safety of the service. Care plans and risk assessments were reviewed and audited regularly and were up to date. Audits were also completed in relation to health and safety, fire safety, medicines and cleaning. Any action required had been completed. This showed staff compliance with the registered provider's procedures was monitored. Any issues with the building were referred to the housing provider for action.

People who used the service, their representatives and staff were asked for their views about the service and they were acted on. House meetings were held every week in each house and topics discussed included activities, meals and holidays and household issues such as decorating. Where issues were raised, action had been taken by the registered manager.

Questionnaires were sent out to family members and professionals regularly by the registered provider, and two had been returned from families and one from a community professional. The responses were very positive. We saw from records the service had regular contact with relatives and representatives and took their views into account.

Staff meetings were held approximately every month. Topics discussed included individual tenants needs and goals they had achieved, infection control, incident reports, healthy eating, the team plan and dignity, optional training available, safeguarding and whistleblowing and policy updates. Actions from the last meeting were discussed and goals were set from the meeting. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

The registered manager told us they felt supported by the registered provider, and they were able to contact a manager at any time for support. They said they enjoyed working for the organisation and worked well as a team to support each other.

The area manager visited the home regularly to provide support and to complete audits and ensure compliance with the provider's policies and procedures. Information was passed to the registered provider regularly regarding incidents, complaints, supervision, health and safety and other issues. The provider's quality assurance team visited the service twice a year to undertake a detailed assessment of the service and completed an action plan to address areas for improvement, which the registered manager worked towards. This demonstrated the senior management of the organisation were reviewing information to drive up quality in the organisation.

The registered provider held regular managers' meetings and training to help managers keep up to date with good practice. The registered manager told us they had completed nationally recognised qualifications in managing health and social care, were signed up to safety alerts and used CQC and NICE guidance to improve their practice. The registered manager was being recognised by the registered provider by being nominated for a learning and development award for their work in relation to supporting people and staff through a complex mental capacity and best interest ruling from the Court of Protection. The registered manager kept records of the information and learning gained to share with other registered managers and teams. This demonstrated they were focused on continuously learning and improving the service, as well as sharing their learning across teams.

The management team worked in partnership with community health professionals to meet people's needs and drive up the quality of the service. We found there was never any delay in involving partners to ensure the wellbeing of the people using the service.

The registered provider understood their responsibilities with respect to the submission of statutory notifications to CQC. Notifications for all incidents which required submission to CQC had been made.