MacIntyre Care

Anvil Close

Inspection report

21-24 Anvil Close
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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

We inspected Anvil Close on 20 and 26 March 2018, the first day of the inspection was announced, the provider knew we would be returning for the second day.

At the last inspection, the service was rated Requires Improvement.

At this inspection, the service was rated Good.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Effective and Responsive to at least good. At the last inspection, there was a breach of legal requirements in relation to person-centred care.
At this inspection, the provider had made improvements to meet the relevant requirements.

Anvil Close 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. Anvil Close is a residential service providing care for up to 12 adults with a range of learning difficulties. There are two flats on the ground floor and two flats on the top floor each with three bedrooms. People with more complex needs live in the ground floor flats. There were nine people using the service at the time of the inspection. 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.

There was a registered manager 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.

At the last inspection, we found that care plans were not always up to date and therefore did not accurately reflect people's individual needs. Accurate records were not always kept in relation to medicine administration records and stock levels of medicines. Staff did not always receive regular supervision to support them in their role. At this inspection, we found there had been improvements in all of these areas.

People were supported to take part in activities in the community and maintain their interest in hobbies. The majority of people went to day centres during the week. The people that were at the service at the time of the inspection looked happy and content. They were supported appropriately by staff.

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.

Relatives of people using the service told us their family members were safe and they had no concerns about their wellbeing. They told us they were kept informed about any changes to the care and support their family members received and were able to visit them at any time. People and their relatives were given information about how to raise concerns and they told us they were confident their concerns would be heard and responded to.

Staff told us they felt supported by the management team and were happy with the training and supervision they received. There were robust recruitment procedures in place and new employees received an induction which included an introduction to the values of the service. Records showed that care workers received regular training in a number of relevant topics and regular supervision.

Up to date and accurate records were maintained. These included records of when people had been supported with their medicines, risk assessments and care plans. Care plans were person-centred and included guidance on the most effective ways to communicate with people, including those with limited verbal communication. There was evidence that internal and external professionals were involved in people's care which meant people's needs were met appropriately. These included positive behaviour support analysts and community health professionals.

People's needs in relation to the premises were met. The service was undergoing a programme of refurbishment at the time of the inspection.

The registered manager was aware of her responsibilities in relation to regulatory requirements and appropriate notifications were submitted to the CQC.

A number of audits were completed including those in relation to health and safety, infection control, medicines and finances. An improvement plan which was reviewed on a regular basis by the registered manager and area manager was in place to monitor progress against the issues found.

The service was transparent and worked with relevant external stakeholders and agencies.

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 has improved to Good.

People received their medicines as prescribed and accurate medicines records were maintained.

There were robust recruitment procedures in place and there were sufficient staff employed.

Staff were trained and understood their role and responsibilities for maintaining standards of cleanliness and hygiene in the premises.

When people behaved in a way that challenged others, staff managed the situation in a positive way that protected people's dignity and rights.

Is the service effective?

Good

The service has improved to Good.

Staff received regular training and supervision which helped them to carry out their roles effectively.

The service took cultural and religious needs into account when planning meals and drinks, and encouraged people to make healthy food choices where this was required.

People were supported to access healthcare services and received ongoing healthcare support.

Where people were not able to consent to their care plans, they were developed and agreed in their best interest in consultation with staff and family members and other stakeholders.

People's individual needs were met by the adaptation, design and decoration of premises.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service has improved to Good.

People's care records identified their needs, choices and preferences and how these were met and were regularly reviewed.

The service enabled people to carry out person-centred activities and encouraged them to maintain hobbies and interests.

People were given information about how to raise concerns and complaints and this was done in an accessible way.

Is the service well-led?

Good

The service remains Good.

Anvil Close

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 20 and 26 March 2018, the first day of the inspection was unannounced. The provider knew we would be returning for the second day. The inspection was carried out by one inspector.

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 reviewed information we held about the provider, in particular notifications about incidents, accidents, safeguarding matters and any deaths.

During the inspection we were only able to have limited conversations with two people as they were not able to communicate with us effectively. We spoke with two relatives after the inspection. We contacted 26 health and social care professionals to gather their views of the service and heard back from six of them. We also spoke with the registered manager, five care workers and the area manager. We reviewed a range of documents and records including three care records, four staff records, as well as a sample of other records such as audits, complaints and training records kept by the service.

Good

Is the service safe?

Our findings

At the last inspection, accurate records were not always kept in relation to medicine administration records and stock levels of medicines. At this inspection, we found there had been improvements in this area.

The service was clear about its responsibilities and role in relation to medicines. Each person had a medicines profile with details about the medicines that had been prescribed, how they were administered, how consent was taken, any allergies and other relevant information. People receive their medicines as prescribed. Staff kept accurate medicines records and medicines were counted to be correct against the records kept.

Staff received annual training and competency in medicines. All the senior care workers were completing a level three qualification in the use of medicines in social care which would allow them to carry out staff medicine competency checks.

Care workers had a good awareness and understanding of abuse and knew what to do to make sure that people were protected. Where people were not able to communicate verbally, records documented how staff could identify whether they were at risk of abuse and potential tell-tale signs to look for. These records also included whether they needed to support people to report abuse.

The provider had effective safeguarding systems and procedures and took appropriate action and notified the relevant local authority safeguarding team when concerns were raised within the service. A safeguarding group consisting of directors and area managers met every three months. The group produced newsletters to disseminate to services, reviewed policies, shared good practice, raised awareness and monitored alerts and investigations.

Individual risk assessments were in place for people covering areas such as personal care, medical and health and safeguarding. These included details of the hazards, how staff were supporting the person to manage the risk, any extra action required to further mitigate the risk. A night time evacuation flow chart was on display in the staff office with guidelines for both waking and sleep in staff to follow if there was an incident that required the premises to be evacuated. Staff were aware of risks to people's wellbeing and how to manage them.

When people behaved in a way that challenged others, staff managed the situation in a positive way that protected people's dignity and rights. Details of how some people exhibited behaviour that challenged, what this manifested as and how staff should manage these situations were included in care records. Behaviour support plans with known triggers and behaviours displayed, what a good and bad day typically looked like and strategies for staff were also included. The provider referred people for assessment to appropriate professionals when they displayed behaviour that challenged.

The area manager and the health and safety manager received monthly reports of any incidents which helped them to monitor them and identify any trends.

A healthcare professional said, "A particular proficiency of the home is their ability to identify potential risk when a resident is coming to hospital and the potential consequence of being in a busy environment where normal routines are likely to be shattered. It is my experience that members of staff give this great consideration and then implement appropriate risk reduction strategies."

There were enough staff employed to meet people's needs. Staff levels were reviewed and adapted according to how many people were at home. The registered manager told us the usual staff levels were five or six staff during the day and evening and three care workers at night, two waking and one sleep in staff. On the first day of the inspection, there were three care workers on duty and the registered manager supporting two people.

Recruitment systems were robust and made sure that the right staff were recruited to support people to stay safe. Staff recruitment was managed by a central team in collaboration with the registered manager. The registered manager shortlisted candidates and all recruitment checks were carried out by the central team. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as standard practice. The DBS provided criminal record checks and barring functions to help employers make safer recruitment decisions. There was a two stage interview process, the first stage was where the candidate was invited to the service to meet and greet people and observations done of how they interacted with people. The second stage involved completing a psychometric test which assessed their suitability for a career as a care worker. This helped to ensure appropriate staff were recruited to support people.

Staff were trained and understood their role and responsibilities for maintaining standards of cleanliness and hygiene in the premises, including infection control and food hygiene training. We observed care workers cleaning communal areas using appropriate equipment during the inspection.

A health and safety inspection was completed every quarter. This showed that daily checks such as fridge and hot water temperatures checks, checks on mobility aids, emergency lighting and food hygiene were recorded and completed on time.

A specific infection prevention and control audit had been recently completed looking at risk assessments, staff training and competency, policies and procedures, actions from this were incorporated into an improvement action plan.

Good

Is the service effective?

Our findings

At the last inspection, staff did not always receive regular supervision to support them in their role. At this inspection, we found there had been improvements in this area.

Care workers told us they received regular training and supervision. Training was a mixture of e-learning and face to face. Staff training was monitored through an internal training system from which the registered manager was able to produce monthly reports showing the training that staff had completed. The registered manager provided us with a copy of the latest training matrix. Senior care workers were provided with training on how to deliver effective supervision to care workers. Care workers also attended training which highlighted the importance of regular supervision and its benefits. We saw evidence that care workers received regular supervision during which they were given the opportunity to discuss their wellbeing, any training needs, review their practice and focus on their development.

We observed a care worker supporting a person to eat and they did this in a calm and reassuring manner. They took their time and did not rush them. People's preferences in relation to their mealtimes and also their level of independence in relation to food preparation were recorded. The service took cultural and religious needs into account when planning meals and drinks, and encouraged people to make healthy food choices where this was required.

Referrals were made to both in-house and external services where this was required. For example, people were referred to the in-house positive behaviour support team as a result of behaviours that challenged. The provider also worked closely with another service when a person moved to a more independent style living arrangement and maintained contact with the person once they had moved out. A health professional said, "I worked with [the registered manager] to support one of their previous resident to move onto a bespoke placement of their own. [The registered manager] and the team worked incredibly hard to work jointly with the client's new staff team to ensure they understood the client's needs. They had excellent documents summarising his support needs, including detailed accounts of his daily routines, clothing and food preferences."

People were supported to access healthcare services and received ongoing healthcare support. Each person had a health folder with details of their health support needs, their prescribed medicines and a record of their health appointments. Hospital passports were in place for each person, giving information with regards to their health to be passed to NHS services in case of a hospital admission. A health professional said, "It is my experience that whenever a resident of the home attends or is planning to attend St George's (Hospital), there is an immediate telephone notification from the manager or another staff member. The purpose of these calls will always centre on how any potential distress can be minimised and how reasonable adjustments can be planned."

Correspondence from health professionals and advice sheets in relation to healthcare such as for diet and podiatry were seen in addition to referral letters to health and social care provider. The registered manager told us they had recently started using a new optician who carried out home visits for eye tests. This had

proved beneficial for people using the service who were reluctant to go for an eye test in unfamiliar settings.

People's individual needs were met by the adaptation, design and decoration of premises. The premises were undergoing extensive refurbishment at the time of the inspection. All the flats were being refurbished with brand new kitchen units and to make the communal kitchen/dining area more spacious. People's bedrooms and en-suite bathrooms were also being refurbished in line with their individual needs and they were involved in decisions about the refurbishment to their bedrooms which were being redecorated in line with their chosen colour schemes and décor.

Specialist or adaptive equipment, such as hoists were available and maintained as and when needed to deliver better care and support.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

A record called 'choice and control' in people's care records gave staff information about the type of decisions people were able to make for themselves, those decisions they needed some support with and those they needed full support with. These included simple decisions such as choosing what to wear and personal care to more complex support to find healthier food options and full support with regards to finances and access to medical appointments.

A restrictions checklist was in place for people who lacked the capacity to consent to them. All restrictions were documented and a judgement made whether they met the criteria for DoLS. The provider submitted applications where it was determined that people were deprived of their liberty.

Where people were not able to consent to their care plans, they were developed and agreed in their best interest in consultation with staff and family members and other stakeholders. Details of the people that had been consulted were recorded in their care plans.

A health professional said, "I can recall a different occasion last year when [a person] had a hospital admission. [The registered manager] arranged to meet with the Doctor who was proposing the intervention and myself, to explore best interest decision making under the Mental Capacity Act and to establish the reasonable adjustments that would be required to minimise distress for the individual but to also offer them the best opportunity for a successful outcome."

Good

Is the service caring?

Our findings

We observed care workers treating people with kindness and respect during the inspection. We observed a care worker supporting a person to eat and they did this in a calm, reassuring manner.

Feedback from people who use the service, their families and friends was positive; this was evident in our conversations with them and also in feedback surveys that were carried out by the provider. One health professional said, "[Person] who attends the exercise class often displays behaviours that might challenge, due to a combination of learning disability, personality and ageing. The member of staff who accompanies them to the session always displays a calm, straightforward, patient and caring approach in the face of these behaviours, which always resolves any situations that occur, and helps the client get the most out of the sessions."

People were supported to maintain and develop their relationships with those close to them. People were free to visit their family, friends and the community. Details of how staff could support people to maintain their independence was included in their care records.

Care plans were person centred and included details of people's history, their likes and dislikes, their religious and cultural wishes and the activities they enjoyed. This information helped staff to support people more effectively. Where people did not have the capacity to consent or agree to their care plans, these were completed in their best interest with input from people who were important to them and who knew them best. One person using the service was supported by an independent advocate to help them make decisions so they could be involved in making decisions about their care and support. Regular link worker meetings took place. If people were not able to fully participate in these, the link worker completed these records with any changes or updates in relation to health/medicines, tenancy issues, money, communication and community activities.

People's right to privacy and confidentiality was respected. Staff had a clear understanding of the boundaries of confidentiality. Care workers were careful to seek permission and rang the doorbell to each flat before entering. They explained how they maintained people's dignity when they supported them with personal care.

Good

Is the service responsive?

Our findings

At the last inspection, care plans were not always up to date and therefore did not accurately reflect people's individual needs. At this inspection, we found there had been improvements in this area.

People's care records identified their needs, choices and preferences and how these were met and were regularly reviewed. People's daily routines for the morning, afternoon, evening and night-time were recorded, providing staff with details about how people liked to spend their day. Each person was allocated a link worker who was responsible for ensuring their care and support needs were met and records updated accordingly.

A number of internal specialist teams and groups were available for referrals if greater support was required. For example, there had been some incidents of behaviour that challenged involving a person using the service, these were documented and a referral made to a positive behaviour support (PBS) analyst for review. The PBS lead did a site visit and with a local PBS coach carried out a PBS skills audit and observations and checked their care plan. The local coach was a care worker who had been trained in PBS techniques.

The provider complied with the Accessible Information Standard by identifying, recording, sharing and meeting the information and communication needs of people with a sensory loss. Guidelines for staff on how best to communicate with people were documented in their communication plans. These included types of verbal and non-verbal communication techniques to be used and also helpful hints to improve communication. Pictorial staff rotas were on display letting people know who would be supporting them. Visual activity boards were available for people with pictures of their typical week and showcasing people taking part in the activities.

A health professional said, "It is my experience that the members of staff who support residents to hospital are adaptable; they know their residents well and exercise communication strategies that result in positive outcomes."

The service enabled people to carry out person-centred activities and encouraged them to maintain hobbies and interests. People using the service took part in a provider led activities program called 'London cats', where they took part in monthly activities based on particular themes, for example Valentine's day in February, Easter in March and other events such as picnics. People also pursued activities that interested them, for example their love of cars and radios.

Staff encouraged people to access activities by arranging for external agencies to facilitate them.
The majority of people using the service attended various local day centres during the week. One person using the service did not attend any day centres during the week but took part in activities within the service. People had weekly planners outside their rooms giving them information about their weekly schedules.

People were given information about how to raise concerns and complaints and this was done in an

accessible way. Pictorial complaints procedures and easy read instructions with details of the registered and area manager providing people with information on how they could complain were posted outside their flats.

There had been no recorded complaints since the previous inspection.

Good

Is the service well-led?

Our findings

The provider had a clear, person-centred vision 'For all people with a learning disability to live a life that makes sense to them.' The provider had a way of working called 'Great Interactions' based on ten key facilitation skills, or ways in which care workers engaged with people. Care workers were familiar with these skills which they were introduced to at induction. The registered manager and senior care workers monitored practice against these values during their supervision. The 'great interactions' team were available for referrals and there was evidence that people who needed a greater level of engagement had been referred to the team for advice and support.

The registered managers understood the importance and responsibility of their role. 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.

The registered manager was aware of her responsibilities in relation to regulatory requirements. Notifications were submitted to the CQC for any safeguarding concerns that had been raised and any Deprivation of Liberty Safeguards (DoLS) authorisations.

The registered manager had made some changes to the roles and responsibilities within the home so that reporting and management responsibilities were clear. There were four senior care workers, each assigned responsibility for one of the flats. The care plan record keeping and updating was also done under each senior care worker where previously they were not done so. Staff felt this was beneficial and helped to ensure records were suitably maintained.

The registered manager met with the area manager and the registered manager from a nearby service every quarter, discussing common areas such as staff supervision/appraisals, compliance, training and maintenance.

Team meetings were held monthly, care workers were given the opportunity to discuss any updates with regards to people they supported. The provider held annual staff awards ceremonies to celebrate those staff that had gone above and beyond their usual duties.

An annual survey was completed, care workers supported people to complete this or it was completed by family members on their behalf. We reviewed the feedback received and saw that it was positive.

A number of audits were completed including those in relation to health and safety, infection control, medicines and finances. These were comprehensive in scope and each area checked was given an overall rating and actions identified for follow up and to make improvements. An improvement plan based on the shortcomings found in the audits was seen with each action assigned to a staff member with deadlines for completion. This action plan was reviewed on a regular basis by the registered manager and area manager.

The service was transparent, collaborative and open with all relevant external stakeholders and agencies. It worked in partnership with key organisations to support the care provision, service development and joined-up working.

Special interest groups were set up within the organisation to bring staff across the organisation together who were supporting people in that area. For example, there was a dementia special interest group to share best practice around supporting people at risk of developing dementia. Other groups included safeguarding, great interactions, Positive Behaviour Support (PBS) and autism.

The PBS team worked in close partnership with the British Institute of Learning Disabilities (BILD) since they launched The Centre for the Advancement of Positive Behaviour Support (CAPBS) which was set up to support the organisational and workforce development of Positive Behaviour Support. This involved training McIntyre's PBS coaches who provide PBS to services. The provider also worked with the Ann Craft Trust, a national charity which exists to minimise the risk of abuse of disabled children and adults at risk. A member of the Ann Craft Trust sat on the provider's safeguarding group.