St Martin Of Tours Housing Association Limited

St Martins of Tours Housing - 158-162 New North Road

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

St Martins of Tours provides residential care for men with forensic psychiatric histories and mental health problems. There are 18 rooms for people with mental health problems and/or substance misuse issues and a nearby three bedroom house for people who were transitioning to independent living. There were 16 people using the service at the time of this inspection.

This inspection took place on 7 November 2016 and was unannounced. Our previous inspection in May 2014 found that the service was meeting all of the legal requirements that we looked at during that inspection.

At the time of our inspection a registered manager was employed 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.

We saw that risks assessments were in place and were regularly being reviewed. The risk assessments encompassed potential risks associated with people's day to day support needs, mental healthcare support, other healthcare conditions and risks associated with daily living and activities. Staff demonstrated that they were aware of how to mitigate risks and instructions were clear and informed staff about action to be taken to reduce risks and how to respond if new risks emerged.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. The service was applying MCA appropriately. Physical restrictions under DoLS were not applied for at the service as some people using the service was subject to a community treatment order. This would mean that if they did not comply with their treatment in the community they could be recalled to undergo treatment in a secure hospital ward.

We found that people's health care needs were assessed and the service had begun developing specific health action plans to ensure that these assessments improved the range of potential health care needs assessed, whether previously known about or not. Recovery action plans were also being developed. Care was planned and delivered in a consistent way and the service had regular contact with community mental health services and other health and social care professionals. Information and guidance provided to staff about what was expected of them and the procedures used at the service were clear.

The service complied with the provider's procedures to carry out regular audits of all aspects of the service. The provider carried out regular reviews of the service and sought people's feedback on how the service operated. The four people using the service who spoke with us all said they were consulted and that their views were listened to.

At this inspection we found that the service met all of the regulations we looked at.

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. People's safety and any risks associated with their care were identified and reviewed.

The service had systems in place to ensure that they recruited staff that were safe to work with people.

Medicines were managed safely and consent to the service keeping people's medicines was obtained from people using the service. Where people required depot injections (slow release injections to provide medicines associated with enduring mental health difficulties) the home liaised with community psychiatric services to ensure these were provided and monitored.

Is the service effective?

Good

The service was effective. Staff received regular training and supervision as well as appraisals, staff we spoke with confirmed this as did records we were shown.

Staff understood how to assess and monitor people's capacity to make decisions about their own care. Support was provided to maintain people's mental well-being and to respond to deteriorating mental health conditions.

People were encouraged by staff to maintain a healthy and balanced diet and were provided with guidance, along with practical assistance on how to do this.

Healthcare needs were responded to with any changes to each person's health being identified and acted upon.

Is the service caring?

Good

The service was caring. Staff were observed interacting with people in a respectful way and engaging people about their plans as well as other day to day living activities.

Staff had a good knowledge of people's characters and personalities. Staff showed that they understand the signs to look which could show that people required more support.

Is the service responsive?

Good

The service was responsive. People were actively engaged in making decisions about their care. People we spoke with told us this did happen and could include the involvement of relatives where appropriate as well as other health and social care professionals.

Is the service well-led?

Good

The service was well led. Staff we spoke with felt that the service was well managed and supportive towards staff and people using the service.

The provider had a system for monitoring the quality of care. The service sought feedback from people using the service, families where appropriate and health and social care professionals. The service was able to demonstrate that it acted on this feedback through action taken to respond to any issues raised or suggestions for improvement. An annual review of the service for 2016 had also recently been published.

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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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced which meant the provider and staff did not know we were coming. The inspection took place on 7 November 2016 and was carried out by one inspector.

Before the inspection we looked at notifications that we had received and any communications with people, their relatives and other professionals. This included local authority safeguarding and commissioning teams as well as other health and social care professionals.

We gathered evidence of people's experiences by talking with four people using the service, by observing interactions with staff and by reviewing records of communication that staff had with people's health and social care supporting professionals. We also received feedback from five health and social care professionals. We spoke with the registered manager, three members of the staff team and the chief executive for the provider organisation.

As part of this inspection we reviewed four people's care plans. We looked at records of medicines provided to people, training, appraisal and supervision records for the staff team. We reviewed other records such as complaints information, quality monitoring and audit information, maintenance, safety and fire records.

Good

Is the service safe?

Our findings

A person using the service told us, "I like the staff I can talk with them." Other people did not make specific comments about feeling safe but did say they felt able to talk with staff.

Staff told us they had training about protecting adults from abuse and were able to describe what action they would take if a concern arose. It was the policy of the provider to ensure that staff had initial safeguarding induction training when they started working at the service, which was then followed up with periodic refresher training. Staff training records confirmed this training did occur.

Staff had access to the organisational policy and procedure for protection of people from abuse as well as the local authority procedures for reporting concerns.

The provider had procedures for the safe recruitment of staff at the service. These procedures included background checks, employment history, references and qualifications all of which had been verified. The registered manager showed us confirmation that these checks had been carried out for the two staff recruited in the last year.

The staff rota and deployment of staff around the home showed there were enough staff on duty to give people individual attention and meet their care and support needs. This included time to work with the three people living at a nearby house which was used as a part of the transition of people moving on from the service to independent living. Support was offered to escort people to appointments if necessary and to attend meetings and other activities outside of the home.

Risk assessments were compiled and updated, either as a part of care plan reviews or more frequently if changes to a person's needs required this to happen. Risk assessments encompassed general risks common for most people and risk assessments tailored to each person's individual care and support needs. For example, risks relating to people's mental health condition, people they associated with and who may pose a risk and behaviours that may pose a risk to either themselves or others.

If anyone using the service was not seen within a 12 – 18 hour period, having left the home, the missing person's policy was implemented. We discussed a recent incident where this had been required and the service had taken the necessary steps and reviewed this incident with the person concerned when they returned to the home.

We looked at four people's medicines administration record charts (MAR). Staff had fully completed these and people had received all their medicines as prescribed at the correct times of day. We checked these people's medicines stock and found these were correct. Where people took responsibility for administering their own medicines, this had been assessed and compliance with self-administering medicines was monitored, not least where missing medicines could affect people's mental well-being. Training records showed that staff were trained in supporting people with their medicines. There were guidelines in place for staff to ensure that people received their medicines appropriately and signed consent from people to keep

and administer medicines was obtained.

Some of the people using the service also received depot injections, which are slow release injections of medicines used to alleviate symptoms of mental ill health. These were not carried out by staff as people were independently expected to attend local clinics that provided these injections. The service monitored that people were receiving these as required and were contacted by the clinic if people were not attending for these injections.

The provider had arrangements in place to deal with other common potential emergencies such as risk of fire or other environmental health and safety issues. Fire alarms were tested regularly and other safety checks, for example gas and electrical safety, were being carried out.

Good

Is the service effective?

Our findings

People using the service told us, "I meet my keyworker every week but I can also talk with any of the staff" and "Staff ask me how I am getting on and I see my keyworker every week."

Staff training records provided details about which training courses staff had done, and when they did them. Staff attended regular training updates which included refresher training on standard core skills that staff were required to have. For example, mental health, human rights and conflict resolution among other training. A more recently appointed member of staff told us how pleasantly surprised they had been about the level of training that the service provided. Each member of staff we spoke with felt that the training they received equipped them to do their work.

Records confirmed that staff had regular supervision with the registered manager or deputy manager in most cases monthly although the average was rarely over six weekly. Staff undergoing their induction had supervision more frequently at first then monthly throughout their six month probation period. An annual appraisal system was in place and this was used for all staff to assess their performance and development.

We attended the staff afternoon shift handover. Staff shared information about what support had been provided to people on the early shift, contact made with health and social care professionals, events at the service and how the support would be managed for the rest of the day. This demonstrated that staff planned their work in view of the current needs of people using the service on a given day.

The service operated a zero tolerance policy around drug use. Agreements with people about zero tolerance to substance misuse were signed. The service responded quickly to any incidents of people not adhering to these agreements and liaised with placing mental health teams when these issues arose. Care plans reflected peoples past histories of drug and alcohol use as well as their mental health conditions.

People were involved in planning their transition plans, care plans, risk assessments, advance plans and learning and reviewing their recovery with staff. People we spoke with told us these things did happen. People s who had their care managed by the Forensic and Assertive Outreach Teams saw their care team regularly as well as their consultant psychiatrist. Care plans demonstrated that there was detailed information about multiagency working and communication with other health and social care professionals. The service obtained people's signed consent to their care plan which we found on each care plan we reviewed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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.

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

Each of the staff we spoke with had a good knowledge of their responsibilities under the Mental Capacity Act (MCA) 2005. Staff were also aware of the Deprivation of Liberty Safeguards (DoLS). Staff were able to tell us what this meant in terms of their day to day care and support for people. The service was aware of the need to carry out best interests referrals for assessments but only very infrequently was this needed.

Physical restrictions under DoLS was not applied at the service as some people were subject to a community treatment order. This would mean that if they did not comply with their treatment in the community they could be recalled to undergo treatment in a secure hospital ward. The service focused on encouraging people to be pro-active with being involved in taking action to address their mental well-being.

Everyone using the service was expected to cater for themselves. The manager told us that the service provided a light breakfast and encouraged people to join in as a way of trying to establish a daily routine and prepare for their day. People were encouraged by staff to maintain a healthy and balanced. Guidance, including advice from a dietician was provided on how to do this as well as providing a weekly cooking lesson. People were expected to shop and cook for themselves but staff support in doing this was available in order to develop daily life and budgeting skills.

The care plans contained a health action plan, although these were still being developed. The health action plans outlined general and more individually specific healthcare needs, for example the physical ill health resulting from a history of alcohol and substance miss use. People in this situation were supported by staff to manage these healthcare needs and attend check-ups and other appointments.

Good

Is the service caring?

Our findings

People told us, "Staff are helping me to find work and get ready for interviews", "I am looking at moving on next week and staff are really helping me" and "Sometimes other people get overbearing but I do talk to staff and it gets dealt with."

People's individual care plans included information about their cultural and religious heritage, daily activities, including leisure time activities, communication and guidance about how support should be provided. As a part of the rehabilitation programme people were supported to develop external interests in the community, for example attending further education courses and community based mental health support services, such as drop in centres. In discussion with staff it was evident that they knew about people's unique heritage and care plans described what should be done to respect and involve people in maintaining their individuality and beliefs.

The provider had a detailed equality and diversity policy which emphasised that everyone, whether living or working at the service, had the right to be treated in a respectful and dignified way. The provider was a partner with the British Institute of Human Rights which was undertaking a programme of training and developing methods of working which placed human rights at the core of how services operated. None of the people, whether using the service or staff, raised any concern about not being treated in a respectful or dignified way.

Health and safety room checks were carried out on a regular basis in line with the terms of the placement agreement. People were informed of when to expect the checks. Staff told us they would only carry out an unannounced check if they were concerned for a person or unless it was an immediate emergency. There was a clear policy and guidance for staff about when and how checks of this kind should be carried out.

Staff demonstrated that they were knowledgeable about how to respond calmly to behaviours which were challenging. Incidents of this nature were recorded and responded to. A debriefing process took place after any incident including the people involved, staff at the service and other health and social care professionals if required. Events were reported to care management teams and this occurred in every case, regardless of how minor the incident may have been.

People's independence was promoted and it was the aim of the service that people learn and regain their abilities to be independent, often after long periods undergoing treatment for addiction and mental health difficulties. We observed staff engaging with people about their activities for the day and meetings or other events happening for them.

When allocating staff to work with people, we were told that the service considers the ethnicity and skills set of staff. The policy of the service, particularly if someone is finding it difficult to cope with the more independence based ethos, is to move people on to more appropriate services rather than evicting them as this can potentially have long lasting effects on the person in the sense of rejection and failure.

Good

Is the service responsive?

Our findings

People told us "I know who to complain to, I did make a complaint recently and it was dealt with", "I am listened to and can talk to anyone" and "They (staff) are doing a really good job."

Care plans covered personal, physical, social and emotional support needs, and progress was updated daily on an electronic care plan record. A report on progress was then produced each month by the person's keyworker and was shared with the community health or social care professionals responsible for each person's care management. The updates could take place more frequently as required, for example after any adverse incidents that may have occurred. Care plans included details of discussion with people using the service and reflected their views generally and as a part of their specific weekly meeting with their keyworker.

Care plans were well organised. Information was easy to track, both in terms of historical information about people's background and psychiatric treatment and progress regarding current recovery plans.

During the staff handover we observed that staff were all able to go into significant detail about people's progress and current needs. The service was in regular contact with community mental health teams and some people, although not all, at the service was under the Care Programme Approach (CPA). The care programme approach is designed to reduce the amount of time people spend in hospital and continue their treatment, often lasting a number of years or the rest of a person's life, within the community. Some people were subject to certain legal restrictions, for example, Community Treatment Orders, and where there were incidents of people not complying with these the service quickly took steps to involve community mental health teams. These specific legal conditions were recorded in care plans.

There were arrangements for some people about making contact with the service due to their vulnerability or the specific conditions of their placement. CCTV was used to monitor the communal areas of the building and the entrances and exits. This helped to ensure people's safety and could be used to review incidents, although it should also be noted that serious incidents are not frequently reported for this service and anything that did occur was addressed quickly.

Social care professionals who contacted us were highly positive about how the service responded to people and liaised with them. The professionals told us that the service was recovery focused and focused very well on this. They also complimented the way in which the service informed them of client's progress and communicated about any issues which arose.

The complaints policy outlined the way in which complaints were responded to and was clear. Following complaints from neighbours in early 2015 the service had amended its procedures to include regular contact with neighbours and walks around the neighbourhood to monitoring of people using the service when out in the local area. This was designed to identify and respond to any issues quickly. There had been no further complaints about these previous issues and formal complaints of any kind were rarely made. The people we spoke with who used the service in general commented about how readily they felt able to speak

with staff so any emerging issues were dealt with quickly rather than escalating to formal complaints.

Good

Is the service well-led?

Our findings

People did not make specific comments about their view of the management of the home, however, it was evident from our observations that people felt able to speak with staff in general and this included the manager.

We asked staff about the leadership and management of the home and the feedback we received showed that there was trust in the way the service was managed.

There was a clear management structure in place and staff were aware of their roles and responsibilities.

Records showed and staff told us that there were monthly team meetings. Minutes from the three most recent staff meetings showed that staff had the opportunity to discuss care, developments at the service and other topics.

The home's manager and deputy manager were required to submit regular monitoring reports to the provider about the day to day operation of the service. This was done by a computer based system which meant that the provider could see current information about the service and any actions needed. There were monthly visits by the providers chief executive officer who was the responsible individual. They examined areas such as care planning, the environment and staffing matters. A written report was sent to the service after each of these visits and the recent reports we looked at showed that any matters needing attention were quickly identified and responded to.

The provider had an organisational governance procedure which was designed to keep the performance of the service under regular review and to learn from areas for improvement that were identified. The service developed plans to address the matters raised and took action to implement changes and improvements as well as a business plan covering the years 2015 to 2017. A staff survey was also underway for this year and the plan for this survey reported on action taken in response to last year's survey.

The provider used an external organisation to conduct an annual survey of people using the service, stakeholders and staff. The most recently published survey from February 2016 showed that people's responses were largely positive, and 88% of people who responded felt that they had a good or high degree of satisfaction with the service overall. An action plan had been devised in response to the 2016 survey, this had been shared with people using the service and a timetable for completing the actions had been implemented across the provider organisation.