St Martin Of Tours Housing Association Limited

Wilton Villas

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

Wilton Villas provides residential care for men who may have mental health issues , a substance misuse issue or a learning disability. The service can accommodate up to 23 people with mental health problems and/or substance misuse issues, each person having their own bedroom. The service recognised that some people may have an additional learning disability so a specific five bed flat within the building was created for people with a mental health, substance misuse history and who also have a learning disability. There were 18 people using the service at the time of this inspection.

This inspection took place on 31 May 2018 and was unannounced. At the last inspection on 25 April 2016 the provider met all the legal requirements we looked at and was rated good.

At this inspection we found the service remained Good.

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 risk assessments concerning people's day to day mental health and other support needs were detailed and were regularly reviewed. There were clear descriptions of potential risks and information for staff about action to be taken to reduce risks and how to respond if new risks emerged. A psychologist employed by the provider took part in assessing potential risks for people. The service liaised with other community based health and social care professionals in order to minimise and respond to potential risks and to keep people safe from harm.

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 almost everyone 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 if necessary.

People's health care needs were assessed and the service had introduced health action plans to ensure that the range of potential health care needs were met, Care was planned and delivered in a consistent way in co-operation with community mental health services and other health and social care professionals. Information and guidance was provided to staff about what was expected of them and the procedures used at the service.

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 provider worked well to ensure that people were included in decisions about their care. People's views about how the service was run were respected and taken seriously.

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**

Wilton Villas

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 31 May 2018 and was carried out by two inspectors and an expert by experience that had knowledge of using mental health services.

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, other health and social care professionals and the police.

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 spoke with the deputy manager and four members of the staff team as well as the operations manager.
As part of this inspection we reviewed four people's care plans. We looked at records of medicines provided to people, training, supervision and appraisals for staff. 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, "Yes, they give you medication, if you miss your medication they come and knock on your door to remind you and you take your medications downstairs as soon as possible."

Other people told us they felt safe although one said not always as people disagreed with each other and could be rude. This was regarding people that lived at the service but not about staff.

Staff told us they had training about protecting adults from abuse and could 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 that this training did occur and had been updated in the last year.

Staff had access to the organisational policy and procedure for protection of people from abuse which was in line with the local authority procedures for reporting concerns. Staff conformed they were trained in this area and training records showed this training took place.

The provider had procedures for the safe recruitment of staff at the service. These procedures included background checks, employment history, references and qualifications (where relevant) all having been verified. The registered manager showed us confirmation that these checks had been carried out for the six staff recruited in the last year. A newer member of staff told us, "I got a tour of the building, met the staff, met the residents, discussed running of the service it was a lot to take in the two week induction. On those days you work 9-5 before going onto the rota."

The staff rota and deployment of staff around the home showed that staffing levels were suitable to meet people's needs. This included one to one support being offered to escort people to appointments if necessary and to attend meetings and other activities outside of the home. Support was flexible and took people's needs into consideration. Staff told us that there were locum staff used to cover absences but these were people that knew the service.

People's needs were assessed taking into consideration general and specific risks. For example, we found risk assessments in people's care plan files covered areas such as, physical healthcare conditions, activities and signs that showed if someone may be becoming unwell either physically or mentally. There were clear and detailed examples of how risk assessments were tailored to each person as well as risks that were common for all people. For example, people's daily activities in the home or relating to their mental health condition at any given time. We saw that risk assessments were reviewed regularly and were updated when people's needs changed, not least in terms of people's mental health condition.

We looked at ten people's medicines administration record charts (MAR). Staff had fully completed these which indicated that 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. We did note that where guidance

was provided by the pharmacist about signs of potential overdose of medicines this had not been included on the MAR charts, which the deputy manager informed us would be rectified. 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. Staff were trained to administer medicines but no update training was provided. We spoke with the provider about this and they provided us with an action plan to introduce mandatory two yearly medicines refresher training. Competency assessments were not routinely undertaken but were a part of the refresher training. We were told by the deputy manager that competency assessments were, however, undertaken if a medicines error had been identified during medicines audits.

Some, but not all, 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 a local clinic that provided these injections or community psychiatric nurses would visit to administer these. The service monitored that people were complying with their medicines regime and liaised with mental health services if this was not occurring.

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. People were discouraged from smoking in the building and risk assessments were in place regarding this, as well as people being challenged if they were smoking in their room.

We were informed of a cleaning issue on the ground floor corridor near the bins but the area was clean when we looked. The deputy manager told us that there was a pest problem and the service have requested wheelie bins which they hope will improve the situation.

The service employed a domestic worker each day, the service was kept clean internally aside from the issue referred to above which the deputy manager said would be addressed. Apart from the refurbished 5 bedroom flat in the building we saw other areas which needed redecoration and refurbishment, for example hallways and communal areas.

We were told the psychologist wishes to bring in PIE (psychologically informed environment), which should make the building feel less institutional. We were subsequently supplied with a plan for redecoration works that were to take place in different communal areas of the home in the coming months.
The provider had recognised that improvements were needed and was taking action to resolve these environmental issues.

Good

Is the service effective?

Our findings

People told us, "Yes they are [effective]. Been here two years, no problem with manager, deputy and other staff, no problem at all", and "Yeah, sometimes we debate and argue but we always shake hands. I prefer female staff."

Staff training records provided details about which training courses staff had done, and when they did them. Staff attended regular training, for example, mental health, safeguarding, mindfulness and wellbeing which we were told was most often face to face in small groups at head office. Staff had a positive view of the way in which they were trained and supported to do their work. A member of staff told us "Training feels constant with a lot of in house training. Basics about mental health, safeguarding, DOLS, conflict resolution."

Records confirmed that staff had regular supervision with the registered manager or deputy manager at least every six weeks. 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 relevant information about what support had been provided to people on the early shift, events at the service and how the support would be managed for the rest of the day. This showed that staff planned their work in view of the current needs of people using the service.

The service operated a zero tolerance policy around drug use. Agreements with people about zero tolerance to substance misuse were signed and filed. 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 people's past histories of drug and alcohol use as well as mental health conditions. There was detailed information about multi-agency working and communication with other health and social care professionals, for example psychiatrists, substance misuse professionals, community psychiatric nurses and mental health teams. The service obtained people's signed consent to their care plan.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.

All 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). The service was aware of the need to carry out best interest's referrals for assessments if there was a question about people's capacity to make specific decisions and we saw an example of this for one person. We were told by the deputy manager that best interests decision procedures were used infrequently.

There was a DoLS authorisation in place for one person using the service. This had been subject to the required authorisation which was held on the person's care plan file. Five other 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 for treatment in a secure hospital ward. We saw two recent examples of the service liaising with mental health services in response to deterioration in mental health needs and the need to be recalled to hospital for treatment.

The approach taken at the service was for people using the service to cater for themselves. However, a breakfast club happened each morning. This was used to encourage 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 diet. Guidance, including advice, for example from a specialist diabetic nurses, was provided on how to do this as well as providing cooking lessons. 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.

Care plans contained information about general and more individually specific healthcare needs, for example, diabetes. A person living with this condition told us, "If my blood sugar gets low I press my alarm if I can reach it or I will phone on my mobile." They also told us that if they had needed to do this they got a response from staff. Aside from mental health conditions some people had other physical health issues relating to alcohol or substance misuse. 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, "Yeah, trouble comes from the people not the staff. They protect me as best as they can" and "Of course, they tell you when they come to your room, ask permission, knock on your door." One person told us about showers and baths getting blocked which we passed onto staff to attend to which they said they would.

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. There was a cooking group once a week, run by an external person, a relaxation group, yoga. Mindfulness, a fortnightly men's group and a hearing voices group was facilitated by staff.

Health and safety room checks were carried out on a regular basis and people were informed when to expect these checks. Unannounced checks were carried out if staff were concerned for a person's well being.

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, which included a review by the clinical psychologist employed by the service. Events were reported to care management teams, regardless of how minor the incident may have been.

People attended regular monthly meetings with their keyworkers and discussions and outcomes were recorded. Keyworkers are members of staff who are allocated to coordinate the care planning and updates of each person's progress. Care plan files showed the discussion topics which were in line with their agreed care plan. The attendance at keyworker meetings varied but on the four care plans we reviewed, at least a monthly keyworker session was attended by people and in most cases more than once a month.

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

Good

Is the service responsive?

Our findings

One person told us "I have a very good rapport with the Director: if something needs doing he gets it done or tells the manager, the Director is here often." Another said about staff responses to them that, "They intervene discreetly one hundred per cent of the time." This person went onto tell us about something that had happened and how they felt that staff had responded to it well.

Care plans covered personal, physical, social and emotional support needs, and progress was updated regularly by each person's key worker. They were updated 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.

During the staff afternoon handover, which we observed, staff were all able to have detailed discussions about people's progress and current needs. Staff were aware of people's care plans and signs to look for that indicated people's mental health condition may be deteriorating and required a response from them. The service was in regular contact with community mental health teams and some people were subject to 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 people were not complying with these the service took steps to involve community mental health teams. The treatment conditions were recorded in care plans.

There were specific arrangements for some people about contacting 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. The use of CCTV was known about and explained to people in line with the provider policy.

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 service promoted equality and diversity amongst people using the service and the staff team. We saw diversity information was available in the communal areas of the service. The service provided accommodation for people, and employed staff, from different cultural and religious backgrounds. From our interviews with staff and people, we learnt that individual religious needs were catered for and different cultural backgrounds were celebrated. For example, at the staff handover the team discussed who was choosing to fast as when we visited the Muslim religious period of Ramadan was taking place.

Staff told us they thought the service was good at promoting equality and diversity. One told us "I think there is good equality and diversity here. Some here are fasting. If someone is fasting I'll not eat in front of them.

It's about being respectful. I won't impose my religious views on others or how they should vote. I don't think anyone here is LGBT [lesbian, gay, bisexual and trans]. If someone was saying homophobic things though I would encourage to desist." No one using the service who we spoke with made any comment about this although care planning did consider LGBT as well as other areas of diversity and human rights.

The complaints policy outlined the way in which complaints were responded to and was clear. The service, in response to complaints from some neighbours in 2015, had amended its procedures to include regular contact with neighbours and walks around the neighbourhood and 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 complaints about behaviours and noise up to late 2017. There had been improvement, although some specific incidents involving people using the service were recorded in the last year. The provider could demonstrate that continuing action, including liaison with neighbours, the police and local authority, was undertaken.

The service did not specialise in providing end of life care.

Good

Is the service well-led?

Our findings

People told us, "Yes, he [registered manager] does his job, if something needs to be done he deals with it, if you make a complaint he deals with it". "He encourages you to make complaints" and "Yes, good man, very good man, very good, no problem with him, no problem at all."

We asked staff about the leadership and management of the home and were told that team working was effective. We were told, "I am happy working here. It's not perfect, but nowhere is. The deputies are trying to make positive changes" and "We're trying to make it one culture. The recovery approach is the value of the organisation."

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

There was open communication between the staff team at the service, which we observed. Records showed and staff told us that there were monthly team meetings. Minutes from the most recent six 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 representatives of the provider who were senior members of the provider's management team, and on occasion visits from trustees of the charity or chief executive, who 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 four most recent we looked at showed the service was being monitored appropriately by the provider.

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. An incident log was compiled each month with details of the incident type and the action taken in response. This demonstrated that the service was keeping significant events under review and action was being taken in response.

The provider conducted an annual survey of people using the service, stakeholders and staff. The most recently published stakeholder survey for 2017 to 2018 received a very low response rate, the report referred to what the provider would do to explore this and seek a higher response rate. No themes, apart from a slight fall in overall satisfaction, were referred to in that report. The provider stated in the report that themes would be addressed on a service to service basis as the report covered each of the three separate services it operated. A survey of people using the service had been carried out earlier in 2018. Action points from the feedback that people had provided and an action plan had been compiled with each action point implemented immediately, for example to be involved in more provider meetings at head office rather than just at the home, and we were informed how this was being achieved.