St Martin Of Tours Housing Association Limited

Wilton Villas

Inspection report

Wilton Square
London
N1 3DN

Tel: 02073599990
Website: www.stmartinoftours.org.uk

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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 with mental health problems, substance misuse and learning disabilities. There are 23 rooms for people with mental health problems and/or substance misuse. The service recognised that some people may have an additional learning disability so created a specific five bed flat within the building was created for people with a mental health, substance misuse history that also have a learning disability. There were 24 people using the service at the time of this inspection.

This inspection took place on 25 April 2016 and was unannounced. Following our previous inspection in January 2014 we undertook a focused inspection to look into concerns about the service. That inspection took place on 12 March 2015 and looked into concerns about people's safety as the result of incidents that had required the police to be called to the service or people having been involved with the police in the local area. We found at that time the service had taken action to address those concerns and the situation had improved. Positive relationships with the local community had been established, a recent garden party event hosted by the service had occurred and the feedback received had been very positive.

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 concerning people's day to day support needs, mental healthcare support, other healthcare conditions and risks associated with daily living and activities were detailed and were regularly reviewed. Instructions for staff on how to mitigate risks were clear and informed staff about action to be taken to reduce risks and how to respond if new risks emerged. A psychologist that was also employed by the provider took part in assessing potential risks for people.

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.

We found that people's health care needs were assessed and the service was introducing specific health action plans to ensure that these assessments improved the range of potential health care needs assessed, whether previously known about or not. 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.

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.

Is the service effective?

Good

The service was effective. Staff received regular training and supervision as well as appraisals.

Staff understood how to assess and monitor people's capacity to make decisions about their own care and support and to respond to deteriorating mental health conditions.

People were encouraged by staff to maintain a healthy and balanced diet and provided guidance on how to do this as well as providing cooking lessons.

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 way that showed they treated each person as individuals and they demonstrated concern for people's well-being.

Staff had a good knowledge of people's unique characters and personalities, as well as their understanding of signs to look for that could show that they required more support.

Is the service responsive?

Good

The service was responsive. People were actively engaged in making decisions about their care. This included the involvement

of relatives where appropriate and 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.

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 25 April 2016 and was carried out by one inspector and specialist professional advisor 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 as well as other health and social care professionals.

We gathered evidence of people's experiences by talking with three 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 three social care professionals. We spoke with the manager, deputy manager and three members of the staff team.

As part of this inspection we reviewed six 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, "Yes I do [feel safe], they are very nice and do nice things for you. If there was potential of harm I think you could tell them and they would deal with it."

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 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 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 (where relevant) all having been verified. The manager showed us confirmation that these checks had been carried out for the six staff recruited in the last year.

We asked whether people living at the service thought there were enough staff two people told us, "No, I need help to go shopping and sometimes there isn't enough staff to go with me" (we followed this up with the manager who said they would ask the person about this) and, "Yes, sometimes they're in meetings but they tell you you've got to wait 5 -10 minutes and they do get back to you."

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 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.

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 twelve 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. 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.

Almost 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. 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.

The service employed a domestic worker for three hours a day during the week. The manager told us this would be increased to seven days a week shortly. Apart from the newly refurbished 5 bedroom flat in the building we saw other areas which were in need of redecoration and refurbishment, for example the kitchens. The manager showed us an action plan for works to be carried out in the coming months to address this.

Good

Is the service effective?

Our findings

People told us, "The main keyworker keeps records about me and their concerns" and "Yes, they [staff] are knowledgeable, my psychologist is trained, the keyworkers know how to support me and refer you to other things (meaning offering guidance and support to access other services)."

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, learning disability and keeping people safe from harm. Staff had a positive view of the way in which they were trained and supported to do their work. They said, "We get training and it is expected that we attend", "We have very good relevant training, most recently about learning disability as we have identified that some people may have that issue too" and "We have so much training, not least when I started my induction."

Records confirmed that staff had regular supervision with the 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 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 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 peoples past histories of drug and alcohol use as well as mental health conditions. There was detailed information about multiagency 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 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.

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). 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. We did see a recent example when this process had been undertaken and the necessary consideration was given to the decision being taken.

Physical restrictions under DoLS was not applied at the service as almost everyone 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. However, we did see a recent example of where the service had encouraged someone to undergo hospital treatment voluntarily rather than be sectioned under the mental health act. The service viewed it as important to try to encourage people to be pro-active with being involved in taking action to address their mental well-being. This could have the added benefit of reducing the length of hospital in patient treatment and lead to a speedier overall recovery from an episode of mental ill health.

Everyone using the service was expected to cater for themselves although a breakfast club had recently been started. 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 for example from 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.

Two of the six care plans contained a health action plan. When we raised this with the manager, he commented that these had been introduced recently and were in the process of becoming established for everyone. The health action plans that had already been compiled contained information about general and more individually specific healthcare needs, for example, diabetes. One person described the staff as knowledgeable and skilled. As a diabetic, they were monitored at the local diabetic clinic. They told us they were pleased with how the service supported them with this. 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, "Yes, they [staff] try to encourage me to take part in activities, for example, when they want to speak with me or when there is art group they always let me know." Another person said, "They can be inpatient sometimes [but did not expand on why they thought this] but I don't blame them. They take an interest in what your needs are."

People also said "Yep, every time they see me they greet me, ask me how I am and they look out for interest" and "Yes, can't think of an example [referring to whether they were treated with dignity] but they keep confidentiality"

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 plan's 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. No one who spoke with us 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 would only carry out an unannounced check if they were concerned for a person or unless it was an immediate emergency.

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. 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 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.

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.

Good

Is the service responsive?

Our findings

One person told us if they had a complaint they would, "First complain to key worker or manager". Other people said, "Yeah, I converse with them [the staff] and I feel they take an interest like the way they promote my book [the person had recently published a book of poetry]" and "Yes, they are often trying to find out how I am."

Another said about staff responses to them that "Yes, the occasional treat to McDonalds or helping to clean my room or showing me how to use the washing machine."

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.

Some care plans were better organised than others. Some medical reports and benefits letters were misfiled in the incorrect section. We raised this with the manager who told us that it would be raised with the staff team to ensure that information was readily accessible in the correct part of the care plan files.

During the staff handover we observed that staff were all able to go into significant detail about people's progress and current needs. Staff were aware of individual care plans and signs to look for that people's mental health condition may be deteriorating and require a response. The service was in regular contact with community mental health teams and almost everyone 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 conditions were recorded in care plans.

There were specific 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.

Social care professionals who contacted us were mostly positive about how the service responded to people and liaised with them. One professional had raised a concern earlier this year about the service response to people using legal highs (substances that have a mood elevating effect but are not classed as illegal substances in the UK). The professional told us that the service had responded satisfactorily and had taken action on this concern. We discussed the response of the service to the use of these substances and were told that the zero tolerance policy extended to "legal highs" as well as the use of illegal drugs and alcohol. Information displayed on posters at the service made it clear that the zero tolerance policy covered all of these substances, whether legal or not.

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 a few recent complaints about noise, which the service had responded to. A garden party event was held recently which was hosted by the service and included local residents. This event was designed to forge better understanding with the community about the service and its work as well as to allow people to meet, greet and get to know each other. There had been a marked improvement in the view that people held about the service which was evident by comments that people had made and by a request from neighbours to hold future events.

Good

Is the service well-led?

Our findings

People told us, "He's [the manager] alright, very supportive and helpful" and "I'm kept informed about possibilities to better my life and I would like to say that the general support here is really good. I've never had no trouble here."

We asked staff about the leadership and management of the home and were told that team working was effective.

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 were told and observed. Staff views about how the service operated were positive and the staff team was well co-ordinated. 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 a representative of the provider who were senior members of the provider's management team, and on occasion trustees of the charity, 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 six 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. 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.

The provider used an external organisation to conduct an annual survey of people using the service, stakeholders and staff. The most recently published survey for 2015 to 2016 received a 71% response rate, although the final report did not detail how many of the respondents were living at Wilton Villas, but did refer to any themes from feedback for the service. The responses were largely positive, and 92% 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 2015 to 2016 survey and a timetable for completing the actions had been implemented across the organisation.