

Brighton Housing Trust

Shore House

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement



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

The inspection took place on 5 December 2018 and was unannounced. The previous inspection took place on 6 and 10 May 2016 when the service was rated as 'Good.'

Shore House is registered to provide care and accommodation for up to 20 people who have needs associated with mental health and/or alcohol and substance misuse. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service aims to assist individuals with mental health needs in their recovery and move on to more independent living opportunities. The service accepts referrals for people who are already living in the community, as well as people who are inpatients at the time of referral. The service has been jointly commissioned by Brighton and Hove NHS and Clinical Commissioning Group (CCG) and Brighton and Hove local authority.

The service is situated on the sea front in the centre of Brighton and is near a range of facilities. Accommodation consists of 20 independent living units. Four of these were self-contained flats with a kitchen, bathroom and bedroom. Four flats had a bedroom and kitchen and the remainder did not have a bathroom or kitchen. There were several communal lounges and kitchens for people to use.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection. We have made two recommendations in the report regarding ongoing monitoring and assessment of risks to people.

Radiators were not covered or assessments carried out to ensure people were protected from hot surface temperatures. Risks to people were assessed but these were not always recorded. This included people's ability to safely prepare and cook food as well as any risks of fire where people smoked in their rooms. We have made a recommendation about this.

People's needs were assessed before they moved into the service. Staff also attended multi-agency planning meetings called the Care Programme Approach (CPA), which are coordinated by the referring mental health services. We noted copies of the CPA meeting decisions were not held with people's care records so the provider would have all relevant information about people's needs. We have made a recommendation about this.

People said they felt safe at the home. Support workers had a good awareness of the principles and procedures for safeguarding people in their care.

Sufficient numbers of support workers were employed to ensure people got the support they needed.

Medicines were safely managed.

There were systems to review people's care and when incidents or accidents had occurred.

Support workers well trained in the methods used by the service to support people to develop their independence and recovery from mental illness and substance misuse, which was a system called the Outcome Star. This assessed people's abilities to live independently and to progress to being more independent. Staff said they felt supported in their work. People said the support workers were helpful and supported them to develop their independence. There were arrangements in place to support people to maintain and develop skills in meal preparation. The provider and support workers worked with local health care services to ensure people go the right health care. 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.

The ethos of the service was focussed on promoting people's rights to live independently and to treat people equally irrespective of their needs or disability. People described the support workers as caring and approachable. People were consulted and involved in decisions about their care and support. People's privacy and choice was promoted.

People received support which was individualised to meet their assessed needs. As part of the service's aims and objectives, people were supported with a range of activities to develop independence and for supporting them to manage their mental health. The provider had a complaints procedure and people said they were able to raise any issues if they needed to. There have been no complaints made to the provider.

There were systems to check and audit the quality of the service provided which included seeking the views of people. The provider was forward looking and worked with local community and hospital mental health services to provide a service which met the aims of mental health care services in the Brighton area. Local health care commissioners told us, "It is a responsive service that will work closely with commissioners to respond to local challenges and to continuing service improvement."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service has deteriorated to Requires Improvement.

Risks to people were not always fully assessed and recorded. Some aspects of the premises were not always checked and assessed as safe. The provider did not always obtain copies of multi- agency CPA meeting minutes and plans.

Medicines were safely managed.

The home was clean and hygienic.

Support workers had a good awareness of their responsibilities to protect people.

Sufficient numbers of support workers were provided to meet people's needs.

The provider monitored people's care and took appropriate action where incidents had occurred.

Is the service effective?

Good ●

The service remains Good.

Is the service caring?

Good ●

The service remains Good.

Is the service responsive?

Good ●

The service remains Good.

Is the service well-led?

Good ●

The service remains Good.

Shore House

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

This inspection took place on 5 December 2018 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with four people. We spoke with three support workers, a senior support worker, the registered manager and the provider's senior manager for mental health services. We received feedback from the commissioning CCG who gave us permission to include their comments in this report.

We looked at the care plans and associated records for four people. We reviewed other records, including the provider's internal checks and audits, staff rotas, accidents, incidents and records of medicines administered to people. We looked at the training and supervision records for support workers.

Is the service safe?

Our findings

We noted some areas of health and safety needed to be improved. Radiators were not covered and there was no assessment to indicate if these posed a risk to people or if they needed to be covered. Risks to people were assessed but there were omissions in these. Where people were assessed as being able to safely use kitchen equipment in their rooms this was not recorded. For one person, we also noted that where they prepared food for themselves there was no assessment to show the person could do this independently so they were not at risk of malnutrition. Following the inspection the provider confirmed action was taken to address these shortcomings and forwarded copies of revised assessment formats which included these areas of need. Regular health and safety checks were carried out on people's rooms and included observations of any risks of fire where people smoked, which was included on a fire risk assessment form. However, there was no assessment of the risks to individual people and the premises where people smoked in their rooms. The provider also forwarded revised assessment documentation which showed this was now included in the risk assessments. Whilst these areas were addressed by the provider and we judged these did not have an adverse impact on people, we still recommend the provider ensures risks assessments and the safety of the premises is reviewed and takes account of the guidance in the Health and Safety Executive publication, Health and Safety in Care Homes to ensure people, visitors and staff are protected.

Details of any supervision conditions, such as under the Mental Health Act 1983, were recorded so guidance was in place to maintain safe care so risks were managed. The provider confirmed staff attended multi-agency Care Programme Approach (CPA) planning meetings where people's ongoing care and mental health needs were discussed by mental health services. These take place to ensure hospital after care is safe and well planned. We noted copies of the CPA meeting records were not on people's records. We recommend the provider obtains copies of multi-agency CPA meetings to ensure all available information on people's care and supervision is obtained.

People told us they felt safe at the home. For example, one person said, "The arrangements for my medication keeps me safe. I also get help with my finances." Another person said the security at the home was good and said there was a peaceful atmosphere, "I feel secure here. The security is good. I like it here. There are good staff levels. People can't misbehave. I love the quiet."

Support workers completed training in safeguarding procedures and knew what to do if they had any concerns. The provider informed us that safeguarding of people was discussed regularly at staff meetings. There were procedures in place to protect staff such as a lone working policy and specialist training on dealing with aggression. Walkie-talkies were used by all staff to enable them to maintain contact with each other while working around the building and to call for additional assistance if necessary. Closed circuit television (CCTV) was used in communal areas such as the entrance hall to monitor safety for people and staff. There were policies and procedures about this. People were consulted about the use of CCTV. The provider was committed to the safety of people and had examples where action had been taken to exclude visitors who were disruptive to people.

Risks to people were assessed and there were care plans for staff to follow to counter the risks. These included the risks associated with mental health needs, substance misuse and behaviour. These were well recorded and gave specific details about how to recognise if someone was becoming unwell. There were records of risks and incidents being discussed with people and actions for support workers to keep people safe.

Medicines were safely managed. Medicines administration records (MARs) showed support workers recorded their signature when they supported someone to take their medicines. These showed medicines were administered as prescribed. People were supported to be independent in managing their own medicine following a risk assessment to show the person was safe doing this. People confirmed this arrangement suited them and helped them to be more independent. Support workers were trained in the handling of medicines and this involved an observational assessment that they were competent to do this.

Checks were made by suitably qualified persons of equipment such as the fire safety equipment and electrical appliances. There were restrictors in place on all windows to prevent people from falling or jumping from height. These are monitored in all health and safety checks of communal areas and client bedrooms. There were contingency plans in place in the event of a fire or need to evacuate the premises. A valid certificate of liability insurance was displayed.

People said there were enough support workers and that staff were always available to speak to when they needed. At least two support workers were on duty at any given time. In addition to this there was a group coordinator who ran a programme of activities with people. A staff duty roster showed staffing was well organised. There was also an office administrator. Support workers considered there were enough staff on duty to meet people's needs.

We looked at the staff recruitment procedures. The provider confirmed references were obtained from previous employers and we saw checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. The provider told us the selection of new support workers was based on checking of applicant's approach to working with people and their relevant previous experience.

The home was found to be clean and hygienic. Staff were trained in food hygiene and infection control.

Records showed people's changing circumstances were monitored and when incident or accidents occurred these were discussed with people with the aim of minimising any reoccurrence.

Is the service effective?

Our findings

The provider and staff worked closely with community and mental health teams to ensure people's support and care was delivered in line with current legislation. There was a model of support for people based on an Outcome Star which assessed people's abilities to live independently; this formed the basis of future support planning. The Outcome Star monitored people's progress towards independence. The support workers also used another recognised approach called Psychologically Informed Environments (PIE) aimed at improving the psychological and emotional well-being of people. This involved training for staff and monitoring of its effectiveness. Support workers were committed to this approach and described it as providing person-centred care to people.

Support workers had the skills and knowledge to deliver effective care. A range of training and support was provided to the support workers including courses which were considered mandatory to attend such as, equality, diversity and inclusion, aggressive behaviour, professional boundaries, and safeguarding of people. Support workers demonstrated they understood and promoted equality and diversity, that people had a right to access services irrespective of their needs and any disability. Additional training was provided so support workers developed specialisms which were linked to the provider's approach to supporting people, such as understanding trauma, motivational interviewing, mental health, substance misuse, and, alcohol abuse plus facilitating behaviour change. There was also a range of training for the provider's management team such as in staff performance and supporting staff.

Support workers said they received supervision and felt supported in their work. Reflective practice was promoted whereby support workers examined their work and any impact it had on their emotional well-being and work with people. External support was also provided to the staff team on a monthly basis by a clinical psychologist.

Newly appointed support workers confirmed they received an induction when they started work and that this included a period of shadowing more experienced staff as well as observations of their competency.

Care records showed people's physical and mental health needs were assessed. There was a coordinated multi-agency approach to meeting mental health needs, such as working with the Mental Health Placement Officer and the Mental Health Homelessness Team. Mental health was monitored using an approach called Targeted Intervention to identify if people were becoming unwell. Physical health care needs were monitored and the provider worked with health care professionals when this was appropriate. We observed support workers liaising with a visiting GP regarding a person's health needs; care records were updated on the guidance provided by the GP. People told us they were supported to attend health care appointments. For example, one person told us support workers took them to hospital appointment as they needed this assistance due to excessive anxiety.

People were supported to cook independently and support workers helped people to shop for food when this was needed. People told us they were satisfied with the arrangement for food and said help was available from support workers when needed. Cooking classes were provided and people said they enjoyed

these. Recorded details about people's arrangements for food and meals varied; for example, one person had records to show the level of support they needed with food whereas for another person this was not assessed and recorded. (This is referred to in the Safe section).

The building was generally well maintained. We noted two areas where there was peeling paint and plaster damage in two bathrooms. There was also a leak above a window in a first-floor kitchen. The provider was aware of these and repairs were due to take place to repair them. We observed people using the communal areas. These included lounge areas and kitchens. People showed us their living accommodation which they had personalised with their own possessions to make them homely. There was a garden with seating for people to use. An additional garden space had recently been acquired and was renovated by the staff and people at the home. The provider confirmed the garden provided therapeutic benefits for people who had grown vegetables in the summer.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's records showed they were fully involved in decisions about their care and had agreed to their care plan. Support workers received training in the MCA and had a good understanding of the principles of the legislation. There were no people who were subject to a DoLS authorisation as each person had been assessed as having capacity to be able to consent to their care.

Is the service caring?

Our findings

People said the support workers were kind and helpful. For example, one person said, "Staff are really nice. They are supportive when I have a bad day and we go for a walk, a chat and a coffee which helps. I'm really happy here." People said they had regular meetings with their key workers. A keyworker is a named support worker with prime responsibility for working with specific people. Relationships between the staff team and people were positive and the provider had made changes to facilitate improved communication with people such as sharing meals together. The provider also supported people to receive visitors in a managed way so as to minimise any negative effects on people.

The provider's aims and objectives for the service were to treat each individual in the service with dignity and respect and in a non-stigmatised and non-judgemental manner. These values were demonstrated by the support workers we spoke to. For example, a support worker said they treated people with, "Unconditional positive regard." Unconditional positive regard is a concept developed in counselling where there is an acceptance of the person regardless of what the person has done; this is used in the context of client centred therapy. Support workers also said they treated people with respect and dignity as well as being empathic. Cultural, dietary and religious preferences were acknowledged and catered for.

People were involved in decisions about their care and support. The Outcome Star model of promoting self-development and independence involved the person setting goals which were reviewed on a regular basis.

The provider and staff team were committed to promoting the rights of people to access services such as housing, employment and other care services. People said they were able to choose how they spent their time. We observed people watching television in the lounge areas and spending time in their rooms.

Support workers knew the importance of privacy to people. Each person had their own accommodation with their own door key so they could be secure and private. Support workers only entered people's accommodation with the consent of people, by knocking on doors or by prior arrangement, such as for health and safety checks. The provider acknowledged people's rights to privacy such as having a meeting room which only the female residents used, which was requested by them. People were able to choose the preferred gender of the support workers who assisted them.

Is the service responsive?

Our findings

People received personalised support which met their needs and preferences. People's needs were assessed before they moved into the home. This involved staff attendance at multi- agency care planning meetings when people were due to leave psychiatric hospital. Each person had a referral assessment summary. The provider's own assessment of people's needs used a tool called the Outcome Star. This assessed people's abilities to live independently as well as their mental health, substance and alcohol misuse needs. Intervention was based on the Outcome Star assessment and examples of support given to people included assistance with developing independent living skills and managing their misuse of drugs and alcohol. These interventions were agreed with people and reviewed on a regular basis. People said the support provided by the service enabled them to make the transition to more independent living.

Referrals were made to other services to support people to develop independence and to access community facilities. For example, one person said they worked as a volunteer in a charity shop three days a week. Details about mental health needs were recorded and included details about symptoms so support staff would know what to do if someone became unwell.

People also had access to group sessions on maintaining and managing physical and mental health. An activities calendar was available in a communal area and showed events for people to attend on a daily basis. These included, yoga, self- care and identity, cooking sessions, music sessions, gardening, group meals and promoting health care. People said they enjoyed the activities and were able to choose whether they wanted to attend. For example, one person said they particularly enjoyed the cooked breakfasts at the weekend, whereas another person said they chose not to attend the group sessions.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. The provider was aware of this guidance and had considered this as part of their responsibilities. People's communication needs were assessed and support workers knew how to communicate effectively and sensitively with people. The provider was responsive to people's mental health needs and utilised communication methods such as communication cards or by using a mobile phone at the person's request rather than knocking on their bedroom door.

The provider listened to and responded to any concerns. The complaints procedure was displayed in a hall area so people could see what to do if they wished to complain. There was also a suggestions box for people to use. People said they knew what to do if they wished to raise a concern, which included house meetings where they could raise a complaint or issue. The provider was aware of the Duty of Candour guidance for dealing with complaint. This guidance sets out what a provider must do if they have made a mistake in the provision of care. The provider informed us that there have been no complaints made in the 12 months before the inspection.

Is the service well-led?

Our findings

The service was well-led and the provider had a clear vision and strategy to meet the needs of people. The management team were open to suggestions on how the service and safety could be improved.

The service had a registered manager. 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. There was a system of management structure and delegation to a deputy manager but this post was vacant at the time of the inspection. There was also a senior support worker. All staff received supervision from a member of the management team.

The provider was open and made commitments to making improvements which we identified as being needed. People had opportunities to express their views at the regular house meetings which people said they attended and confirmed they could raise issues or make suggestions about life at the home. Survey questionnaires were used to gain the views of people about the service and had been carried out in 2017 and 2018. The results were generally positive. For example, one person stated on a survey questionnaire completed in 2018, "I feel I'm important and that staff have empathy and I belong." The results of the surveys were summarised and where people had responded negatively this was included as an action on the service improvement plan. The service improvement plan, which commenced in July 2018, included ideas and suggestions from people and staff. This showed the provider involved people and staff in its service evaluation and development.

Visual checks were made on health and safety in people's rooms and communal areas such as ensuring areas were free of obstructions. Checks were made on any monies which were held for safekeeping on behalf of people.

Support workers knew the importance of maintaining accurate and contemporaneous records as well as confidentiality of information. The provider was aware of the need to protect information on both staff and people and the guidelines as set out in the General Data Protection Regulation (GDPR), which was effective from 25 May 2018.

The provider had policies and procedures regarding equality and diversity and was committed to promoting this at the service for both staff and people who lived there. The provider had an equality, diversity and inclusion working group which was open to suggestions from people and staff. Support workers showed they were committed to promoting the rights and diversity of people, which they said was always included in the service people received.

The provider and staff worked with commissioners from the Brighton and Hove NHS CCG and the Brighton and Hove local authority. The provider submitted regular data to the CCG as part of the commissioner's monitoring process that the service was meeting a range of key performance indicators (KPI). The CCG told us, "The service performs well in response to commissioned KPIs in the context of a challenging

environment e.g. high system pressures in the acute service, increasing complexity of need."