National Schizophrenia Fellowship

Suffolk House

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

Overall summary

This inspection was carried out on 19 January 2016 and was unannounced.

During our inspection on 11 June 2013 we found that detailed assessments of people's physical health needs were not always carried out. Records of people's medicines were not always accurate and arrangements for the safe storage of medicines were insufficient. A follow up inspection on 31 December 2013 found the service compliant.

Suffolk House works in partnership with the local NHS mental health Crisis Resolution and Home Treatment Team (CRHTT) and all referrals to the service come through the CRHTT. The service provides accommodation and care for up to 12 people recovering from mental health problems. People usually stay at the service for up to two weeks and are assessed by CRHTT before being discharged to alternative accommodation.

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'.

Summary of findings

Registered persons have legal responsibility for meeting the legal requirements in the Health and Social Care Act 2008 and the associated regulations on how the service is run.

Staff were trained in safeguarding adults and had a good understanding in keeping people safe. They knew how to recognise abuse and who to report to and understood how to whistle blow. Whistleblowing is when someone who works for an employer raises a concern about harm, or a risk of harm, to people who use the service. There were policies and procedures in place for staff to follow.

There was enough staff to support people safely and to meet their individual needs.

Assessments were undertaken to assess any risks to people using the service and steps were taken to minimise potential risks and to safeguard people from harm.

Medicines were stored and recorded correctly.

Safe recruitment procedures were in place that ensured staff were suitable to work with people, as staff had undergone the required checks before starting to work at the service.

Care plans were personalised to the people using the service. People were involved in planning of care and the care plans were then signed by people to ensure they were happy with the care and support listed on the care plan.

People had access to healthcare services such as the GP and dentists.

Systems were in place to ensure staff received regular supervision and appraisal. Staff received induction training and also received regular training to ensure that people were safe and the care provided was effective.

Complaints were managed appropriately and people were aware on how to make complaints.

People participated in a number of activities such as going to football groups, playing games and attending community centres.

People's privacy and dignity was maintained. People were independent and we saw people moving freely around the house and were able to go to their rooms and outside without interruption.

Systems were in place for quality assurance. The manager conducted regular audits, which included welfare and health and safety checks. An unannounced audit was also carried out by the provider’s management team.

Questionnaires were completed by people about the service. However, we did not see systems were in place to analyse the findings of the survey.

Summary of findings

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 was safe.

Staff knew how to report concerns or allegations of abuse and appropriate procedures were in place for them to follow.

Individual risk assessments had been prepared for people and measures put in place to minimise the risks of harm.

Safe recruitment procedures were in place to recruit staff and there were enough staff to meet people's needs.

Good

Is the service effective?
The service was effective.

Staff received induction training and relevant mandatory training to help provide people with effective support.

Staff had a good understanding of the Mental Capacity Act 2005.

Supervision and appraisals were being carried out.

People had access to healthcare professionals and services.

Good

Is the service caring?
The service was caring.

People were supported by staff that respected their dignity and maintained their privacy.

People were treated with respect and helped to maintain their independence.

Good

Is the service responsive?
The service was responsive.

People's needs were assessed and care plans were produced with the individual. These plans were tailored to meet each individual's requirement and were reviewed on a regular basis.

People were involved in activities.

The provider had a complaints procedure and complaints were managed appropriately.

Good

Is the service well-led?
The service was well-led.

Staff told us that the manager was supportive and approachable.

There were appropriate systems in place to monitor the service and make any required changes. Regular audits were undertaken by the manager.

The service sought feedback from people through meetings and surveys.

Good

Suffolk 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 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.

The inspection was carried out on 19 January 2016 and was unannounced. The inspection team comprised of an inspector, a specialist advisor in adult social care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. We also made contact with the local authority and the local mental health NHS trust for any information they had that was relevant to the inspection.

During the inspection we spoke with six people, one relative, two staff members, a bank staff, a visiting social professional and the registered manager. We observed interactions between people and staff members to ensure that the relationship between staff and people was positive and caring.

We spent some time looking at documents and records that related to people's care and the management of the recovery house. We looked at ten people's care plans, which included risk assessments.

We reviewed six staff files which included training and supervision records. We looked at other documents held at the recovery house such as medicine records, quality assurance audits and residents and staff meeting minutes.

Good

Is the service safe?

Our findings

People told us they were safe at the service. One person told us when asked if they were safe, "Yes." Another person commented, "Yes, safe as well as it can be." A relative told us, "He [relative] is safer here."

Staff were aware of their responsibilities in relation to safeguarding people who used the service. Staff files contained up to date training certificates on safeguarding. Staff were able to explain what safeguarding is and who to report to. Staff also understood how to whistle blow and knew they could report to outside organisations such as the Care Quality Commission. Information was available on whistleblowing in the staff office. We looked at the provider's safeguarding and whistleblowing procedure, which provided clear and detailed information on the types and signs of abuse and how to report allegations of abuse.

Staff files demonstrated the provider followed safe recruitment practice. Records showed the provider collected references from previous employers, proof of identity, criminal record checks and information about the experience and skills of the individual. The provider and the manager made sure that staff members were only offered a post when all relevant information had been received which would protect people from unsuitable staff being employed at the recovery house. This corresponded with the start date recorded on the staff files.

Staff had no concerns about staffing levels. The registered manager told us they were currently in the process of recruiting two full-time mental health recovery staff to cover vacancies. These vacancies were covered by bank and agency staff. The service employed three mental health recovery staff during the day, the manager and two mental health recovery staff at night. The registered manager told us there was always an on call manager and in addition, an on call support service was provided by the Crisis Resolution Home Treatment Team (CRHTT) when extra help was needed.

We found assessments were undertaken to assess any risks to people using the service. These were person centred. There was a safety management plan that was completed for each person and this covered risks in areas of violence, self-harm, non-compliance with medicines and disengagement with services. Where a risk had been identified the registered manager and staff looked at ways to mitigate the risk by listing actions to prevent the risk from occurring. The plan provided information on the presenting risks that each person had and also listed stress factors, triggers, prevention strategies and interventions for each person. The plan also listed the actions that staff should take to manage or reduce risks in order to ensure people and staff were safe. People were involved in planning of these risks and the assessments were signed by people to ensure they were happy with the plan. Staff had access to the local mental health NHS trust database to enter comments or concerns on progress people had made. This database was monitored by CRHTT.

Risk assessments and checks regarding the safety and security of the premises were up to date and had been reviewed. These included a fire safety policy, fire risk assessments, regular evacuation drills and weekly fire tests for the recovery house.

We saw evidence that demonstrated appropriate gas and electrical installation safety checks were undertaken by qualified professionals. Checks were made in portable appliance testing and hot water temperature to ensure people living at the recovery house were safe.

We reviewed the incident and accident report for the last twelve months. Appropriate action had been taken by staff working at the time of the accident. Clear records were kept of the investigation that was carried out and any actions taken as a result. Details of these incidents were also communicated to the local mental health NHS trust and CRHTT to reduce any further risks to people that may lead to harm.

The recovery house did not administer medicines; this was administered by CRHTT. People were either self-medicating or under supervision by CRHTT. The recovery house retained records of all medicines brought into the house, which included a statement regarding people's ability to self-medicate. Audit on medicines were carried out on people's medicines and the findings were recorded on people's medicine forms. The medicine summary sheet detailed the medicine, dose, frequency and stock balance and stated where it was prescribed from such as the GP. There was a medicine support plan which gave a summary of how people administered their medicines. This included details such as whether people were self-administering or if medicines were administered by CRHTT. The plan was signed by both people living at the service and staff members.

Good

Is the service safe?

Some medicines were kept inside a fridge. There was a form to complete temperature checks. However, the form was not specific for a medicine fridge as it contained headings for freezer and hot food temperatures. Medicines were stored securely; people had a lockable tin for the storage of medicines in their room. Bedrooms were locked and keys were given to staff members when people went out. Regular checks were made to ensure that bedroom doors were locked when people were out.

Good

Is the service effective?

Our findings

Staff had the knowledge and skills they needed to perform their roles effectively. People we spoke with told us that staff supported them well and understood their needs. Staff had training and this was a mixture of eLearning and face to face training.

Staff told us that they had received induction and this was confirmed in the records we saw. It included shadowing more experienced staff as well as covering training in key areas such as fire safety, COSHH, infection control and health and safety. Staff told us that they were well prepared for their role. Agency staff were provided with six hours of induction. This was an arrangement the recovery house had with the agency to ensure that agency workers had enough information to enable them to work safely and effectively.

Staff had undertaken mandatory training such as fire safety, Mental Capacity Act (MCA), first aid and health and safety. In addition staff had received more specialist training in mental health awareness and challenging behaviour. The registered manager told us that all staff would be enrolled to complete training in suicide prevention and we saw evidence that two members of staff had completed this training already. We found that training had not been provided on the management of epilepsy. The registered manager told us contact had been made with the Epilepsy Association and staff would begin training in March 2016. Staff told us that they had easy access to training and had received regular training. Training needs were discussed during appraisals and formal one-to-one supervision.

We spoke with staff and looked at staff files to assess how they were supported to fulfil their roles and responsibilities. Records showed that the recovery house maintained a system of appraisals and supervision. Formal individual one-to-one supervisions were provided regularly. We saw that the content of supervision sessions recorded were relevant to individual's roles and included topics such as training needs, concerns and individual progress. Supervision also included important information about staff members under key headings such as 'What I want from supervision', What will I contribute as a supervisee' and 'Signs I am feeling stressed'. Appraisals were scheduled annually and we saw that staff had received their annual appraisal in 2015.

People were independent and managed their finances, which included budgeting and purchasing their own food. We saw people had their own cupboards to store food in the kitchen area and there was a small supply of basic food such as cereal, bread, milk, tea coffee that was provided by the recovery house. In the event someone was unable to purchase food, then this would be provided by the recovery house with the assistance from food banks and charities. There were two communal sessions where people had meals together. Every Wednesday, healthy eating was promoted, which included salads, jacket potatoes and smoothies, and every Sunday, lunch was prepared by people to have together. The recovery house partially contributed to the costs of purchasing ingredients for these meals. Records of activities showed that these sessions were held, although records of planning and the type of lunch that was prepared, were not always recorded. We observed people were able to purchase food and prepare their meal of choice in the kitchen area.

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.

DoLS are put in place to protect people's liberty where the service may need to restrict people's movement both in and outside the home. The manager and staff had a clear understanding of DoLS and MCA. The registered manager told us people were not subject to DoLS authorisation and had capacity to make decisions by themselves about their treatment and support. We saw that the front door was open and people were able to go out by themselves.

Good

Is the service effective?

People confirmed that staff asked for consent before proceeding with care or treatment. For example, a staff member asked whether people were happy to talk to the expert by experience and gained their consent before letting the expert by experience speak to them and if people did not want to speak then this was respected by the staff member.

Each care record had a consent form, which was signed by the person, to agree the support to be provided and included consent to communication and records being retained.

We saw records that people were able to visit healthcare professionals such as the GP and dentists. Visits were recorded on people's individual's records.

Records covered the physical health of people. This provided information such as any conditions people may suffer and detailed the medicines people took. People went to heath appointments and accessed all the local services such as the chemist by themselves. This made it difficult to monitor people if they were bringing in extra supply of medicines, illicit substances or alcohol. Records showed that people signed an agreement to ensure illicit substances or alcohol was not bought inside the recovery house and we saw that warning letters were issued when conditions were breached.

Good

Is the service caring?

Our findings

The service had an equality and diversity policy and staff had received equality and diversity training. We observed that staff treated people with respect and according to their needs such as talking to people respectfully and in a polite way. People using the service and relatives told us staff members were caring. One person commented "Yes", when asked if staff were caring and polite. We observed that people had a positive relationship with staff members. One relative commented, "They're [staff] very pleasant and nice." A social professional from Enfield council, who works closely with the recovery house told us, "I have found the service at Suffolk House, Palmers Green to be completely wonderful. The staff have always been professional with me and the clients report that they are happy there."

We saw staff interacting with people and good relations had been formed between people and staff. We saw staff chatting with people about topics of interest and acting in a caring way. We observed one person needed to get to an appointment quickly. A member of staff made telephone calls on behalf of the person and directed the person to the place as well as offering to provide a taxi. However, we did observe on occasions that there was lack of interaction with people. People were either in the lounge or dining area by themselves for a period of time and not engaged in any activities, while staff were completing tasks.

It was evident that when speaking to staff, they had a good understanding of people's individual's needs and preferences and were respectful of them. For example, some people preferred to stay in their bedrooms and staff respected their choice. The visiting social professional told us, "They very much focus on people's needs."

People were independent and staff provided support when it was needed. For example, we saw a staff member explained the contents of a letter the person had received in a caring way. People at the recovery house were living with a range of mental health conditions and were being supported to maintain their independence as much as possible. People were encouraged to be independent by staff and care plans described people's rights and responsibilities whilst in the recovery house and what they were expected to do by themselves within boundaries. We observed people were able to move around independently and go to the lounge, dining area, toilets and hallways if they wanted to. The registered manager told us that most people went on to independent living after their stay at the recovery house.

Staff told us that they respected people's privacy and dignity. All bedrooms were for single occupancy. This meant that people were able to spend time in private if they wished to. People could freely go into their rooms when they wanted and close the door without interruptions from staff and people. A relative told us, "They respect his [relatives] privacy. I think they're very good. Always very approachable." We observed staff knocked on people's door before entering. We did not observe treatment or specific support being provided in front of people that would had negatively impacted on a person's dignity. Staff respected people's choice for privacy. We observed some people preferred to take their meals in their own rooms and this was respected.

People had contact with family members and details of family members were recorded on their care plans. The relative we spoke to confirmed they were able to visit commenting, ""Yes, they're [staff] brilliant. Always welcome."

Good

Is the service responsive?

Our findings

People were assessed before being admitted to the recovery house in order to ensure that their needs could be catered for. Admissions were assessed by CRHTT, the recovery house had limited involvement in the admission or discharge of people. People generally stayed at the recovery house for two weeks. People were given a comprehensive welcome pack by the recovery house, which included important information about fire alarms, house rules and information on the local area. Health questionnaire were completed and risk assessment were also carried out. Staff identified what people's needs were and the support they required upon the person being admitted and ensured that people understood that the recovery house was only available for a temporary stay.

Each person had an individual care plan which contained information about the support people needed. We found that people had input into the care plans and had choice in the care and support they received. Care plans contained information such as past medical history, family situation, treatment, in patient stays, criminal history as well as details of any history of aggression or violence and self-harming behaviour. The information was comprehensive in content. These plans provided staff with information so they could respond to people positively and in accordance with their needs.

Staff responded quickly if people needed any support. Observations showed appropriate intervention by staff when a person became verbally agitated and angry towards one staff member. This was dealt with quickly and the situation was diffused without incident. We saw staff offered explanations about issues such as health appointments and supported people to make appointments when required.

We saw documentary evidence that covered people's prospective on their current situation called 'First look at my situation'. This provided staff information on people's prospective on what they felt was working and what they needed assistance with. This helped staff to understand how optimistic or pessimistic people felt in their current state. There were support plans that covered issues on the support people required such as going back to education and a discharge support plan which included the steps to be taken for people to move on from the recovery house.

Daily progress notes provided an overview of what people had done on the day such as if people went out for a visit, stayed in the recovery house or attended any appointments. The one area that had limited records was 1:1 sessions, which is held with people to review their progress and identify support needs; these were not always identified in the records. The registered manager told us that this was incorporated into the general notes, and not always specifically recorded. There was a daily allocations prompt sheet which identified any specific appointments and prompts for staff to address the standard paperwork with people within the stated time frames. Some documents had to be completed within six hours of admission such as those relating to the assessment and management of safety and risk.

The staff team worked well together and information was shared amongst them effectively. Staff handovers were carried out twice a day where updates on people were discussed as well as potential admissions. Staff signed a form to state that they had read the contents of the file prior to starting a shift. Records confirmed this was being done. Because of the short stay of people and their vulnerable status, there was a lot of paperwork to complete each time and this could detract staff from engaging with people.

The visiting social professional told us that they work with the recovery house to arrange activities for people. Currently, people were involved in a football group and also arrangements were being made to have a session with a poet following requests made by people to be involved in poetry. People also attended local community centres to undertake activities in singing and arts and crafts. The health professional told us, "They [recovery house] are keen to help people move on" and "They do their own activities." Records showed people participated in board games, newspaper discussions and cooking and budgeting groups. In the dining room there was art equipment such as pencils, charcoal and pens on the tables with plain paper and colouring pages. We observed a staff member carried out an art therapy session with a person with these equipment's.

There were procedures in place to handle complaints. The policy provided people who used the service and their representatives with clear information about how to raise

Good

Is the service responsive?

any concerns and how they would be managed. We saw formal complaints had been received and these had been investigated and resolved appropriately to the satisfaction of the complainant.

There were complimentary cards from people that used to live at the recovery house thanking staff for looking after them. Compliments included from one person, “Thank you so much, this has been amazing. I am so glad this place exists.” Another person commented, “Thank you for all your kind support in helping me get back to my healthy state.”

Good

Is the service well-led?

Our findings

During the inspection we found the registered manager and staff were welcoming towards us and information that was requested was readily available.

Staff and people told us that there was a good atmosphere within the recovery house. One person told us, "It's nice as it can be. Probably the best house I've been to."

We observed the environment to be relaxed where people were free to chat and interact with each other and staff members. For example, people were able to freely move around the house and go into different parts of the house and sit down if they wanted privacy.

Staff told us they felt well supported by management. One staff member told us, "They are a phenomenal team and they inspire me." The interaction between staff and the manager was professional and respectful.

Regular staff and residents meetings enabled people who used the service and staff members to provide a voice and express their views. Resident meeting minutes showed people discussed house rules, activities, complaints and health and safety. Staff meeting minutes showed staff discussed training needs, infection controls, activities, safety management plans and information exchange about the people living at the recovery house.

The service had a system in place for quality assurance. We saw that health and safety checks were undertaken around the house. Daily welfare checks were carried out in rooms every two hours to check on people and also covered key areas such as medicines, fire safety, cleanliness, and electrics. The manager told us any issues were discussed with staff members straight away and also in supervisions and staff meetings. We looked at two bedrooms and saw there were window restrictors had been installed. Checks were also carried out by the recovery house on window restrictors to ensure they could not be opened above the required 100mm and force was applied to check the strength of the restrictors and its condition. We saw that an audit was undertaken on February 2013 by a health and safety manager and a service manager from another service and ratings was awarded under key areas such as workplace, fire safety, COSHH, personal safety and training. The registered manager told us the visits were unannounced and the recovery house was due for another audit soon.

The service had a quality monitoring system which included questionnaires for people that were about to be discharged to alternative accommodation. We saw the results of the questionnaires, which was mostly positive and covered important aspects on staff, safety, concerns and support. Comments included, "Staff are perfect, everyone friendly", "I love the staff" and "Safe space to continue my recovery." There was also some negative comments from people such as, "Not enough staff" and "Staff have too much to do." However, we did not see evidence that feedback was analysed and used to make any required improvements to the service. We fed this back to the registered manager who told us that systems would be introduced to ensure survey results were analysed to make any required improvements.