

St Martin Of Tours Housing Association Limited

Chalkhill Road

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	Requires Improvement 
Is the service effective?	Requires Improvement 
Is the service caring?	Good 
Is the service responsive?	Good 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

Chalkhill Road is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission [CQC] regulates both the premises and the care provided, and both were looked at during this inspection.

Chalkhill Road is registered to provide accommodation and personal care for a maximum of 20 people with complex mental health needs. At the time of our inspection 18 people were living at the home.

A registered manager was in post. 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 found that there were shortfalls in the systems to ensure people received their medicines in a safe way. We saw a few examples, where medicines were not administered as prescribed. We also found that some risk assessments were not as detailed. The lack of detail meant that staff may not have been able to support the respective individuals fully.

There was a system to ensure that people were safe and protected from abuse. Staff knew how to recognise abuse and how to report allegations and incidents of abuse. Safe recruitment procedures were in place. We saw that pre-employment checks had been completed before staff could commence work. There were sufficient numbers of staff to support people to stay safe. We also saw there were systems in place to protect people and staff from infection.

Staff received regular supervision and appraisal. They had also received relevant training. People's care records showed relevant health and social care professionals were involved in their care. The home was working within the principles of the Mental Capacity Act 2005 (MCA). There were concerns that people's nutritional needs may not always have been met. This was due to a long-standing provider's policy, which was intended to promote people's independence. This policy has since been changed following our inspection. It is now the provider's policy that people receive cooked breakfast and meals every day if they choose to.

Staff understood the need to protect and respect people's human rights. People's privacy and dignity were respected. People's rights to confidentiality were also respected. Staff had completed training in the new General Data Protection Regulation (GDPR) law. Staff had received training in equality and diversity. People's spiritual or cultural wishes were respected. People were supported with their religious observances. People were supported to be as independent as possible, and where possible, staff assisted people to increase their independence skills. Staff had built positive relationships with people. Each person had a key worker who had special responsibilities for working with the person.

People's needs were largely met. The service's purpose was to provide a good start for people transitioning from hospitals to independent living. People's support plans were based on an evidence-based model for supporting people who are stepping down from secure hospitals, prisons and mental health services. Each person had their needs assessed before moving into the service and the findings of the assessments formed the basis of their care plans. We saw evidence that the service had helped people to achieve their own goals and aspirations. Between 2017 and 2018, the service had helped at least 10 people to move on to independent living.

Although the service monitored the quality of the service, this had failed to identify the shortfalls we found. People had expressed dissatisfaction regarding the preparation of meals. This was not resolved satisfactorily until we pointed it out.

During this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 was not safe.

There were shortfalls in the systems to ensure people received their medicines in a safe way. We saw a few examples, where medicines were not administered as prescribed.

There were sufficient numbers of staff to support people.

People were protected from abuse and avoidable harm. Staff had received training about safeguarding.

Is the service effective?

Requires Improvement 

The service was not effective.

People were supported by external healthcare professionals who provided staff with guidance.

There were support plans in place. However, support plans could have benefited from health promotion interventions.

Staff received training to meet the needs of people using the service.

Staff received regular supervision and appraisal.

There were concerns people's nutritional needs may not always have been met. However, the service has since made improvements.

Is the service caring?

Good 

The service was caring.

People were treated with dignity and respect.

People's privacy and dignity was respected. Staff were knowledgeable about the people they cared for and were aware of people's individual needs.

People were supported to be actively involved in choices around

their care. Their religious and cultural needs were now supported.

Is the service responsive?

Good ●

The service was responsive.

Each person had their needs assessed before moving into the service and the findings of the assessments formed the basis of the care files that were put in place.

There were appropriate arrangements in place to meet people's social and recreational needs.

There was a process for managers to log and investigate complaints including, recording actions taken to resolve complaints.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

The quality audits were not fully effective at identifying the shortfalls in the service we found during our inspection.

People and staff felt supported by the registered manager.

The registered manager notified us of incidents.

Chalkhill Road

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.

We carried out an unannounced comprehensive inspection of this service on 30 October and 2 November 2018.

The inspection was also prompted in part by a notification of an incident following which a person using the service died. We were informed by the service that the incident was not subject to a criminal investigation. Following the inspection, we were informed by the service that the incident was no longer subject to a further coroner's investigation.

However, the local hospital, which was also providing care to the person is carrying out a serious incident review and will update us of their findings. Therefore, we will not refer to this incident in this report pending the outcome of their investigations.

The inspection team consisted of an adult social care inspector, a bank inspector, and an expert by experience. An expert by experience is someone who had personal experience with this type of service.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team also included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

As part of the inspection process we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences that put people at risk of harm. We refer to these as notifications.

We spoke with one relative, seven people using the service, the registered manager, deputy manager and seven project workers.

We also looked at records in relation to nine people to see how their care and treatment were planned and delivered. We looked at records relating to the management of the service, including a selection of the provider's policies and procedures.

Is the service safe?

Our findings

We asked people if they felt safe living at the home. Comments received included, "We feel safe here", "I feel safe because there is enough staff. There are CCTV cameras everywhere" and "You can approach staff anytime for support." However, we found that there were shortfalls in the systems to ensure people received their medicines in a safe way.

We reviewed medicines administration records (MAR) for nine people who received support with taking prescribed medicines. We found some examples, where medicines were not administered as prescribed.

We identified that one person had not received their medicines as prescribed. The person had been prescribed several medicines. One of these was a medicine used for the treatment for Parkinson's disease. However, we found from our inspection of the MARs that this medicine was being administered inconsistently. The deputy manager could not explain reasons for the inconsistencies. Therefore, we could not be assured that medicines were being properly and safely managed in order that the person was in receipt of their medicines as prescribed.

We reviewed a hand transcribed MAR for another person. This stated that paracetamol was to be administered at 9am, 12pm, 6pm and 9pm. However, the summary of product information (SPC), which was kept with the medicines stated that the following dose intervals should be observed: adults including the elderly and children over 16 years, one to two tablets every 4-6 hours as required, to a maximum of 8 tablets daily in divided doses. The deputy manager told us they had not noticed this discrepancy. Therefore, the paracetamol had not been administered as prescribed and there was a risk of the person receiving an overdose of the medicine.

We reviewed a hand transcribed MAR of another person. This MAR stated that the person was to be administered a medicine for prevention and treatment of vitamin D deficiency, one up to four times a day when needed (PRN). However, we noted the pharmacy labelled box, which was dispensed in May 2018 and currently in use stated that the dose was once daily. However, we saw that this medicine was in fact being administered four times a day. We brought this to the urgent attention of the registered manager and the deputy manager, advising them to seek guidance from the GP.

We also reviewed the support given to a person who managed their own medicines. The self-administration medicines agreement and risk assessments had been signed in 2014 with no recorded reviews or updates. The medicines care plan recorded medicines that were no longer on the current MAR. The self-administration risk assessment stated that weekly checks would be undertaken, however, we saw this being carried out inconsistently. This meant that the service could not reassure themselves that this person was taking their medicines as prescribed.

We looked at a sample of care records and found that some improvements were required to some risks assessments and management plans. Although risks to people had been identified, assessed and reviewed, we found that some risk assessments were not as detailed.

For example, we reviewed the community support plan of one person. The person had a diagnosis of a persistent mental health disorder. The community support plan highlighted current risk indicators and triggers. However, the plan did not specify what the mental health relapse indicators were or what behavioural changes staff needed to look for. Therefore, there was a risk that staff might miss specific relapse indicators and would not be able to support the person fully or report back to external agencies any relevant concerns about mental health deterioration. We found similar examples in the other three files we reviewed.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had continued to operate systems to keep people safe from abuse. A safeguarding policy and procedure was in place. Staff had received up-to-date safeguarding and safety training appropriate to their role. Each member of staff we spoke with was aware of guidelines and contact details of the local authority safeguarding team. Staff were also aware they could notify the Commission and the police when needed.

People told us they felt safe using the service. Safe recruitment procedures were in place. This ensured all pre-employment requirements were completed before new staff commenced their employment. At least two references were in place for all staff. A Disclosure and Barring Service (DBS) check had been completed prior to staff commencing work. DBS checks help employers make safer decisions about recruitment.

We spoke with people about staffing levels. One person told us, "We have enough staff. You can approach them anytime." Another person said, "Staff address issues quickly." A third person said, "During the night we have two staff here. You can rely on them whenever you need to." This was a view shared by most people. Our observations were that there were sufficient staff.

The fire risk assessment for the service was up to date and reviewed annually. Each person had a personal emergency evacuation plan (PEEP). This gave guidance to staff to ensure people's safety was protected during the evacuation of the home in the event of fire or other emergencies.

We saw evidence there was a clear process in place for reporting and dealing with incidents and accidents. All incidents were logged and discussed at management meetings. The reporting process involved, completing a form, reviewing of the report and then if required actions added by the home. The home undertook a reflective practice for each incident to ensure continuous learning.

The home was clean. Staff had completed infection prevention and control training and they understood the importance of infection control measures. They used personal protective equipment such as vinyl gloves and other protective measures when handling food or completing personal care tasks.

Is the service effective?

Our findings

We checked to see if people's healthcare needs were met. People told us, "The staff here liaise with my mental health team. They also make sure I attend appointments with my GP." We noted that people were registered with a GP and could see a doctor whenever they needed to, or go to hospital if necessary. Care files demonstrated that people had regular access to external healthcare professionals. People went out to regular medical and health appointments.

We saw that people who were experiencing mental health conditions had their care plans outlining what the conditions meant to them and how they were affected. Some community support plans were detailed. For example, one person had a diagnosis of a mental illness which was chronic and partially responsive to treatment. The support plan was detailed. It stated that their mental health had been made worse by non-adherence to medicines and substance misuse. The treatment plan was for the service to support this person with medicines management. We saw that this had been followed through.

However, support plans could have benefited from health promotion interventions. For example, one person had diabetes. Their care plan highlighted that they experienced pain in their legs and feet and that this affected their mobility. Their care planning would have benefited from podiatry or diabetic eye screening advice. However, this was not in place. In another example, one person was prescribed a cholesterol-lowering medicine. This type of medicines interacts with certain types of food, for example, juice and pulp of grapefruit, pomelos and Seville oranges (not regular oranges). This information would have been useful to the person, but this was not provided either in keyworker meetings or in their care plan.

Staff joining the service, completed an eight-week induction programme to familiarise themselves with the people living at the home, the premises and working practices. There was evidence that new staff had completed the Care Certificate. This is a nationally recognised care industry induction training which sets the minimum standards of knowledge and competence that staff should achieve on completion of the course.

We asked people if staff were competent. One person told us, "Staff here are experienced. They sort out any issue." Another person said, "Some staff are just outstanding. They try very hard." A third person told us, "Staff have helped me to re-gain my life. I would recommend this place."

Staff were further trained and supported to have the right skills, knowledge and qualifications necessary to give people the right support. Training records confirmed that staff had received mandatory training in topic areas such as, safeguarding, medicine administration, Mental Capacity Act 2005 (MCA), moving and handling, health and safety and fire awareness, food hygiene, first aid, and infection control. Staff also completed specialist training in areas which included, forensic pathways and the Mental Health Act, universal credit, recovery approach practical, conflict resolution, personality disorder, acceptance and commitment therapy and mindfulness, and dual diagnosis.

Staff received regular supervision and appraisal. We looked at a sample of records of supervision sessions

which showed staff could discuss key areas of their employment. Items discussed included recent issues involving people they supported, learning and development, work place matters and actions from previous meetings.

St Martin Of Tours Housing Association Limited had not supplied cooked meals throughout the week in registered care homes for the past 15 years as this was part of their policy to enable people to gain independent living skills. However, during this inspection of Chalkhill Road, some people who lived at the home had raised concerns with this arrangement.

We asked people if they got a choice on what they liked to eat. Their feedback included, "We have healthy dinner every Friday night. Sunday lunch or roasted dinner", "Why does the service not provide us with meals?", "Isn't this a care home?", "They are receiving a lot of money every week, can't they provide food?", "Why do we need to cook for ourselves?", "Our money is not enough to buy food. Could they provide money for breakfast?"

One relative told us they were happy about the service. However, the relative expressed concern regarding food, stating that their relative required food tailored to their health condition. They felt the service was not providing sufficient support regarding meal preparation.

Following this inspection, the service reported that they had reviewed their policy and were now offering meals throughout the week to people who lived at Chalkhill Road.

We also 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. The 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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

Care records noted whether people had capacity to make decisions about their care. All people living at the service had mental capacity. The registered manager told us they always assumed people had mental capacity to make their own decisions.

Is the service caring?

Our findings

People we spoke with were happy with the care and support they received. When we asked if staff were caring, people told us, "Yes, staff are kind and respectful" and "Staff are caring. I would have left a long time ago." We found staff communicated with all people in a friendly and caring manner.

The registered manager and staff had a good understanding of protecting and respecting people's human rights. They had received human rights training. They were aware of people's right to privacy, dignity and respect. We asked people if their privacy was respected. One person told us, "Our privacy is respected at all time. If staff don't see me, they come and knock on your door to check if I am well." This view was generally shared by all people spoken with.

The service respected people's rights to confidentiality. Staff had completed training in the new General Data Protection Regulation (GDPR) law. The GDPR law came into effect on 25 May 2018. It is Europe's new framework for data protection laws. It replaced the previous 1995 data protection directive. The service had updated its confidentiality policies to comply with the new law. Care records were stored securely in locked cabinets in the office and, electronically.

The service had a policy on ensuring equality and valuing diversity. This directed staff to ensure that people's personal preferences were respected regardless of their background. Staff spoke knowledgeably about what they would do to ensure people had the care they needed for a variety of diverse needs, including spiritual and cultural differences. People were supported with their religious observances, including visits to church and mosque.

People were supported to be as independent as possible, and where possible, staff assisted people to increase their independence skills. For example, we saw evidence that the service had helped people to achieve their own goals and aspirations. The service provided a good start for people transitioning from hospitals to independent living. People were given opportunities to learn new skills and gain independence. Some of the skills people needed before they could move on to live independently included, managing their personal hygiene, cooking, finances, medicines, community access and employment. Between 2017 and 2018, the service had helped at least 10 people to move on to independent living.

Staff had built positive relationships with people. Each person had a key worker who had special responsibilities for working with the person. Their role involved supporting their key person in achieving their goals and aspirations. The keyworkers met with their key person on a weekly basis. We read minutes of the meetings and we saw they covered a range of topics, including activities, their health, and other issues relating to their needs. This helped them develop meaningful relationships with people and increase their knowledge of people's likes and preferences.

Is the service responsive?

Our findings

People told us that they were listened to and that staff responded to their needs and concerns. One person said, "I can ask them any question. They listen to me." Another person said, "This place empowers you to stand on your own feet and helps you get there."

People's support plans were based a model of care called 'Resilience and Recovery'. This is an evidence-based model for supporting people who are stepping down from secure hospitals, prisons and mental health services. The model is used to enable recovery and to maximise people's independence and safety in the community. We checked to see if the service was designed to support people's recovery and independence.

Each person had their needs assessed before moving into the service and the findings of the assessments formed the basis of the care files that were put in place. Speaking with staff, we found they were familiar with people's life histories and preferences. Overall, the care plans included information about people's support needs and there were assessments in place to mitigate risks. There was evidence of collaboration with other services such as community psychiatric nurse, GPs and psychiatrists.

We saw evidence that the service had helped people to achieve their own goals and aspirations. The service provided a good start for people transitioning from hospitals to independent living. We saw that people were given opportunities to learn new skills and gain independence. Some of the skills people needed before they could move on to live independently included, managing their personal hygiene, cooking, finances, medicines, community access and employment.

During the inspection we met one person who was moving to their own flat on the very day. The person had lived at the service for a few years. He told us, "I am moving now and I am so happy. The staff have helped me a lot." During his stay, he had been supported to enrol on a course with an online university, and had since completed other studies. He had also been volunteering at a local café. This a big achievement for the person as they had never worked before.

There were appropriate arrangements in place to meet people's social and recreational needs. The service integrated with the local community to maintain positive relationships. One person told us, "Last Christmas we invited our neighbours. It was a great gathering. Staff here always encourage us to do activities." We saw that there was a weekly activities programme for people. This was supported by staff to help people become more independent. People took part in a variety of activities and spent time in the local community and supported to attend social groups, football games, gardening, cinema and other activities.

There was a team of internal staff to support people with employment. People were given advice and guidance for CVs, job applications, interview techniques, literacy, numeracy and computer training. Housing advice and guidance was also available. People also took part in a co-production activity. This was used to give an opportunity for people to give feedback about the service to senior managers.

The service was meeting the requirements of The Accessible Information Standard (AIS). As of 1 August 2016, providers of publicly-funded adult social care must follow the AIS in full. Services are required to meet people's information and communication needs. The registered manager was aware of the AIS and a policy was in place. The service ensured that the communication needs of people were assessed and met. People's care plans contained details of the best way to communicate with them and staff were following these.

There was a complaints procedure in place. This set out how people's complaints would be dealt with. There was a process for managers to log and investigate complaints including, recording actions taken to resolve complaints. We reviewed complaints received in the last 12 months and found that these had been responded to in a timely and appropriate manner.

Is the service well-led?

Our findings

People and their relatives spoke highly of the staff. They told us that the service was well-led and that the registered manager had a visible presence in the service. People told us that the registered manager was accessible and approachable. Staff were as complimentary. A staff member told us, "This is a very supportive place to work." However, despite the positive feedback, we identified areas of practice in need of improvement.

Although we found there were systems in place to monitor the quality and safety of the service, this had not identified gaps that were picked up during this inspection or ensured action was taken to address them. For example, we identified that people were at risk of not receiving their medicines in a safe way.

We found that improvements were required in the current system for ordering medicines. The service obtained medicines from a local pharmacy. We saw that medicines were ordered by several members of staff. The service provided a list of medicines to their local pharmacy, who then ordered the medicines required on behalf of the service. This was not consistent with current guidance. NICE guidance: Managing medicines in care homes, 2014 states, 'Care home providers should retain the responsibility for ordering medicines from the GP practice and should not delegate this to the supplying pharmacy'.

People's MARs were either hand written or typed by the service. However, the MAR documents did not refer to which member of staff had written them. This again was not in accordance to best practice. The NICE guidance, 2014, states, 'Care home providers should ensure that a new hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used'. This was not followed.

Whilst the service had responded immediately to some of the issues identified regarding medicines management, their own quality monitoring systems should have enabled them to identify these issues and to respond in a proactive way.

Some people's files did not always contain detail required to support people. For example, copies of the Care Programme Approach (CPA) could not be seen on the files of some people. Staff told us that this was available electronically, however, these were not located. The CPA is a framework used to assess needs, and ensure that people have support for their needs. It was not clear from the community support plans, whether some people were on CPA and if so, what the level was. Therefore, there was a risk that his needs as outlined in the CPA were not being addressed by staff.

In as much as some audits had been carried out, the system in place required improvements. For example, we reviewed three health and safety audits. Two of them were not dated and all did not contain information as to when the required actions were to be carried out. There was no improvement plan in place. Therefore, the service could not make plans accordingly to drive up the quality of the care delivered and minimise risks

for people.

This was a breach of Regulation 17 HSCA RA Regulations 2014 Good governance. The service did not operate effective systems and processes to assess, monitor and improve the quality and safety of the services provided.

The service promoted an open culture by encouraging staff and people to raise any issues of concern. Staff had regular meetings. They told us this provided them with a platform to contribute to how the service was run. Equally, we saw that people were as involved. The service utilised formal processes such as the complaints system, surveys, key worker system and weekly meetings, for feedback from people. Through these systems people could suggest areas that could be improved. Analysis of feedback enabled the service to drive improvement.

Services that provide health and social care to people are required to inform the Commission, of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Risk assessments were not detailed. Therefore, there was a risk that staff might miss specific relapse indicators and would not be able to support service users fully.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The quality assurance systems had not identified all of the concerns highlighted during the inspection and were not robust enough.</p>