National Schizophrenia Fellowship

Wilton Road

Inspection report

44 Wilton Road
Salisbury
Wiltshire
SP2 7EG

Tel: 01722410724
Website: www.rethink.org

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 and 12 December 2018 and was unannounced on the first day.

Wilton Road is a care home registered to provide accommodation and personal care for up to eight people diagnosed with mental health conditions. At the time of the inspection five people were living at the service. There were four bedrooms on the ground and first floors and shared bathrooms. The home had a communal lounge and kitchen and a large enclosed garden which had a smoking area for people to use.

The service had a registered manager in place although they were not present at the inspection. They had recently moved to another home in the group and a new incoming registered manager was on induction. There was an interim manager in place who was conducting the new registered manager's induction.

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.

Risk assessments were in place which identified hazards and the safety measures to follow. These included many aspects of individual's needs. However not all assessments reflected specific identified risks for some people.

People, their relatives and staff told us the service was safe. Staff were knowledgeable about how to recognise and report abuse. Staff were aware of their responsibilities to report any concerns they had and whistle blow if necessary.

Medicines were managed, administered and stored safely. Medicines were administered only by trained staff and the pharmacy carried out audits and competency checks. There was a daily checklist to ensure correct administration.

People living at Wilton Road had capacity to consent to their care and treatment and to make their own decisions. The service was supported by professionals in the community mental health team to monitor people's capacity when they experienced a relapse in their mental health.

Staff were trained and had the skills to support the people they cared for. The service had plans in place to develop staff qualifications and roles and provide key working opportunities.

The staff had a good understanding and knowledge of people's individual needs. People were supported to attend appointments when necessary and encouraged to take professional advice.

The staff team had a verbal handover between shifts and a checklist to ensure important information was

shared. Staff received one to one support to address any concerns or learning needs. However, communication between the staff group was not always effective.

People, their relatives and staff told us Wilton Road was a caring service. People were treated with dignity and respect.

The service was not compliant with the Accessible Information Standard. Care plans were at different stages of development and guidance from professionals for monitoring people's needs were not followed consistently.

People had access to various groups, clubs, activities and the local community. People were encouraged to remain as independent as possible and to maintain contact with friends and family.

There were quality monitoring and audit systems in place which had improved medicines administration. However, these needed time to embed for other areas such as care planning, risk assessments and monitoring charts.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people were assessed and action taken to minimise the risks, however not all risk assessments reflected people's specific needs.

Medicines were managed safely and were securely stored.

Systems were in place to protect people from abuse.

Is the service effective?

Good

The service was effective.

Staff were trained and had suitable skills to ensure they met the needs of the people they supported.

People's needs were assessed by a team of health and social care professionals.

People were supported to prepare, cook and choose their own meals.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about the staff and the care they received.

Staff interacted with people in a kind and compassionate manner.

People were encouraged to develop independence in day to day routines.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

The service was not compliant with The Accessible Information

Standard.

Monitoring charts for mood changes and dietary intake were not completed consistently.

Care plans were in various stages of completion as the service was utilising different methods of assessment.

People could attend groups, clubs and activities of their choice and were encouraged to maintain contact with family and friends.

Is the service well-led?

Requires Improvement

The service was mostly well led.

There had been several changes of manager within the last 12 months, the newly appointed manager was undergoing induction.

There were quality monitoring and audit systems in place but these needed to become embedded and effective across the whole service.

The service worked closely with services in the local community to deliver support to meet people's needs.

Wilton 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.

This inspection took place on 11 and 12 December 2018 and was unannounced on the first day. It was carried out by one inspector and one 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 service. Their experience related to supporting people with mental health difficulties.

Before the inspection we reviewed all the information we held about the service. This included notifications they had sent to us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with four people who used the service and two relatives. We met and spoke with the interim manager, the incoming registered manager and four members of staff. We wrote to two professionals but did not receive feedback.

We looked at documents related to the running of the home. These included three people's care plans and medication records, three staff personnel files and a variety of policies and procedures implemented by the provider.

Good

Is the service safe?

Our findings

At our last inspection in September 2017 we found that temperature checks in medicine cabinets had not been completed or recorded. We also found that medicine bottles did not have opened dates. During this inspection we found the provider had made improvements to the safety of managing medicines. Temperatures of medicine cabinets and fridges were regularly recorded and medicine packets had opened dates on them. During the hot summer months temperature checks were carried out up to four times a day and fans and ice were used to keep the medicines room cool. There were no bottled medicines or covert medicines in use at the time of this inspection.

We checked people's medicines administration records (MARs) and found that all medicines were administered and recorded correctly. 'As required' (PRN) protocols were in place. Medicines were supplied by the pharmacy, in accurately dosed boxes. The pharmacist provided a monthly audit and refreshers in medicines administration and competency for staff. Only trained staff members administered medicines and a policy amendment stated two members of staff were to administer medicines for safety. However, on occasional shifts staff were lone working. This meant only one trained member of staff administered medicines.

Some people were prescribed a specific psychotropic medicine supplied by the community mental health team. They needed regular blood tests to monitor the effects of the medicine. We saw that people were supported to attend the clinic for this monitoring and collect their medicines. We also saw risk assessments in place for people using this medicine stating the likelihood and severity of the risk. Guidance to staff was recorded which included detailed descriptions of the side effects to observe for and what to do if potentially very serious side effects were noted. People were involved in the development of their own risk assessments and had signed to give consent for administration and agreement to its use.

Care plans contained risk assessments for keeping people safe whilst also maximising their independence. One person had an assessment in place which recognised the risk to their personal safety when walking and accessing the community unaccompanied. The person had reduced physical dexterity and mobility. Actions identified included the person asking for staff to accompany them, requesting a taxi, wearing suitable walking shoes and staff reminders to walk on the inside of the pavement. The care plan and risk assessment had been signed and agreed by the person.

We saw several risk assessments in place for people who experienced delusions, suicidal thoughts, depression and anxiety; all of which had evidence of the person being involved in the development of the risk assessment and agreement with the actions. For example, actions for one person included a person agreeing to talk to staff when they were feeling low in mood. The person had agreed for staff to keep their medicines in order to monitor they were taken.

Risk assessments detailed the severity and likelihood of the risk occurring and trigger factors such as when the person was unwell. However, not all risk assessments were specific or accurate enough to identify and minimise risks appropriately. One person's risk assessment stated that the person had a history of taking too

many or not enough of their medicines. This was when they self medicated and needed to adjust the dosage to suit their sleep and ability patterns. This person spent some time away from the home during the week and at these times it was found that not all their medicines had been taken. Actions agreed with the person were to remain at Wilton Road four nights in the week to utilise the support from staff and for staff to hold their medicines. However, there were no actions to minimise the risk of this person not taking their medicines when they were away from Wilton Road, particularly when they were unwell and experiencing a relapse of their mental health.

Another person had a visual impairment which meant '[person] was not able to do the things [they] used to due to [their] deteriorating eye condition'; but there were no risk assessments relating specifically to their sight loss. In addition, the risk assessment templates used by the service were not person centred. The areas of risk on all assessments were broken down into specific categories such as 'mental health and substance misuse'. These categories did not necessarily apply to people's specific risks to their safety.

Staff told us they had training in infection control practices. The home was clean and tidy and people were supported to clean their rooms. The service employed a cleaning service for the communal areas. However one bathroom had run out of towels, the ventilation fan was blocked with dust and it had an unpleasant odour. At lunchtime both tables in the dining room had dried food on them from breakfast which was cleaned when a person brought it to the attention of the staff. This meant there were shortfalls not identified from the staff daily checklist.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. One staff member told us, "If we suspect anything or become aware, we contact our line manager and ring safeguarding" and "If someone is at risk to themselves I would call the 24-hour crisis team or the community mental health team, or if needed the police." Staff had received training in safeguarding practices and procedures and we saw the local authority safeguarding flowchart was displayed, to give guidance to staff.

Staff were also knowledgeable about their responsibility to whistleblow. One staff member said, "If something is going on at work, unsafe or I see bad practice at the service I could whistleblow." Whistleblowing is the term used when a worker passes on information concerning wrongdoing. Procedures ensure that the whistle blower is protected from reprisals when they raise concerns of misconduct witnessed at work.

Staff were recruited safely. Pre-employment checks were completed. These included references, identity checks and DBS. A DBS check allows employers to make safer recruitment decisions and helps to prevent unsuitable people from working with vulnerable groups of people.

There were sufficient numbers of staff to meet the needs of people living at Wilton Road. The interim manager told us that staff worked alone for around 10% of the time in a rostered month. This meant one staff member supported five people. This usually occurred at the weekend when there were no appointments to attend. A staff member said, "We have a fair number of lone working shifts or with agency staff." The interim manager told us that they reviewed the situation with the staff team looking at it from a safety perspective. "We look at the rota and fill shifts from bank staff and [other home] staff first before we look for agency staff." Feedback received from the staff team was that they had decided it was easier for them to work alone rather than have an agency support worker who did not know the people or the routines of the home. The interim manager said, "We have approached the agencies and are looking at a system where we have regular agency staff who are 'booked' on a short-term contract for continuity."

There were usually two members of staff on duty per shift and one overnight. A staff member told us, "Two is adequate, it is the quality of staff we need, their experience and continuity for clients." Another said, "I like working here, but it would be better if we could have more regular staff, be fully staffed. To be more of a team and continuity." The service was actively trying to recruit permanent members of staff but had a bank of experienced staff to call on. Staff told us they liked to work shorter hours 'on the bank' as it gave them more flexibility. The home had also recently joined with another home locally to share experienced staff until their permanent staffing situation had improved.

The people we spoke with said they felt safe. One person said, "They are always ready to help us when we need, it makes you feel safe knowing they are there." A relative said, "[My family member] is definitely safe with the staff, they could always do with more [staff], but the staff that are there, are kind and treat residents well, treating them more like family than clients."

The service had a dedicated system for reporting and recording incidents and accidents and a policy in place for staff guidance. They had a separate system to monitor the management of actions taken. Following a number of medication errors, the interim manager completely reviewed the medication process and procedure. New systems and practices were implemented and medicine errors were significantly reduced. This meant the service had learned from previous incidents and taken appropriate action.

Good

Is the service effective?

Our findings

At our last inspection in September 2017 we made a recommendation about the training on the subject of capacity assessments and best interest decision making. During this inspection we found the provider had made improvements.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

We were told that people using the service had capacity to consent to receive their care and treatment at Wilton Road. Therefore, no-one at the service was subject to a DoLS. The staff we spoke with were aware of the MCA and worked within its principles. One staff member told us, "People can make unwise choices, if someone is assessed as lacking capacity for certain things this would have to be managed, an appointee or court of protection."

We saw consents and care plans were signed by people. This included specific additional consent around medicine management. Where appropriate, people had the relevant legal authorisations in place to manage their finances. The service was supported by specialist nurses from the community mental health team who assessed people's capacity when appropriate. For example, if they had become unwell and required more intensive input from the specialist services. The service had developed their own mental capacity assessments and best interest documentation to use when these were required.

The service worked closely with health and social care professionals to assess people's needs and ensure support was provided in line with best practice. Examples included regular meetings and contact with community psychiatric nurses, the community mental health team and Wiltshire Council adult social care staff. Information from these assessments was used to develop care plans and guidance for staff on how best to support people. Support plans and safety management plans were shared during each staff handover. We saw that the most currently assessed methods to support one person was being followed by the staff team. Guidance included involving the person in their care and treatment decisions and using reassurance and reaffirming positive ideas to support the person.

The service had begun a new training and development programme for staff to attain their Level 3 qualification as a senior mental health care support worker. All staff were expected to undertake new

training which consisted of face to face as well as on line learning. A training schedule displayed in the office gave dates which staff signed up to. This included safeguarding, the mental capacity act and person-centred approaches. Specific training regarding mental health issues was also encouraged, which included schizophrenia awareness, suicide intervention skills and personality disorder.

Staff we spoke with told us, "The training has been good, but they have changed the training site and there is not enough time to do it" and "Because we are doing the apprenticeship they are having to use agency, we spend 20% of our working time on training every week." Another staff member said, "I do feel I have the skills and knowledge to support people here, having the care certificate and Level 3 gives a general base, the legislation we need to work under."

New staff were subject to an induction programme which followed the Care Certificate. The Care Certificate is a nationally identified set of standards that health and social care workers adhere to in their daily working life consisting of the skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. Agency staff were also subject to an induction consisting of service orientation, first aid and emergency procedures. All new staff had a probationary period of six months. A new staff member who was still on induction was complimentary about the training. They stated, "The training is good, on line and face to face I don't mind doing both. I am a lot more confident there is lots of support, watching observing, it's good to have their guidance." Staff had access to one to one meetings with their line manager to discuss their work.

People were involved in planning their meals and had support from staff to shop for groceries on line weekly. Food was generically stored in the kitchen and everyone had access to it all. Some people were attending a healthy eating group with a dietician and were encouraged to reduce their salt intake and increase their vegetables. Other people needed to follow a specific diet such as low sugar. Food diaries were in place for some people to monitor their diets but these were not dated and were completed inconsistently. For example, some parts of the day, or whole days of monitoring were missed. It was not possible to compare the daily records with the food diaries as they were not dated. However, daily recordings showed staff tried to encourage healthier eating and wiser food choices, and where people had declined.

People were encouraged to be as independent as possible when preparing meals. We observed one person preparing their own lunch and they said, "I have fried egg on toast for lunch every day." We did not observe other people eating in the dining room at lunch time but we were told that the main meal was in the evening. One person who enjoyed cooking was baking for the whole home and they did this regularly. Another person said, "I cooked a whole meal the other day with some help."

The home was small but with adequate facilities. There were four bedrooms on the ground floor and four additional bedrooms on the first floor. There were shared bathrooms and communal sitting and dining areas. There was a large enclosed rear garden. A smoking area was in situ for people which was frequently used. People's bedroom doors were painted in bright individual colours, but we did not observe people's private spaces during the inspection. The communal sitting area had some Christmas decorations but it lacked natural light and stimulating pictures or décor. The registered manager told us that this was an area of identified improvement.

Good

Is the service caring?

Our findings

People and their relatives told us that the staff at Wilton Road were caring. One person said, "I like it here the staff are good to us and look after us well." A relative told us they were very happy with Wilton Road and that their relative was very happy. They said, "He has been there for a while and has become emotionally settled." Staff we spoke with told us they enjoyed their job, saying "It's good, I like it, it's rewarding" and "I am so happy working here, I have been here nearly two and a half years and I enjoy coming to work."

One person was experiencing a relapse of their mental health and we observed staff interacting in a gentle and encouraging manner. This method was guided by the community mental health team and we observed a consistent approach from the staff group. The person was able to come into the office and sit with staff, they appeared to be at ease to talk openly and as often as they needed. Staff spoke quietly, and used reassuring language and distraction techniques to support the person to focus on positive aspects of their lives. Their support included lots of emotional support for the person to practise positive thinking and looking forward to particular events as well as exploring new experiences to try. The method was to break down the person's experience into smaller manageable pieces. The incoming registered manager said, "you will slowly get back onto your feet again, let's get through the morning, have lunch and then work on the afternoon."

People were treated with dignity and respect. A staff member told us they "Treat everyone equally, you share your time out and treat them like any other person" and "I speak to them like a friend and have got to know them on a personal level." Another staff member said, "People have their private space, they can lock their door, I knock and they may say come in."

We observed the handover between shifts. Each person using the service was discussed, detailing how they were, what they had done that day and what actions were required. People were spoken about in a respectful manner and positive events were shared, for example if a person had gone out independently or attended a group. Daily records were written using respectful language.

People were supported to spend time with their friends and families. We saw from records that one person was supported to look for accommodation near to their family and where they had a voluntary job. Another person was supported to have more contact with their family member. People's families and friends could visit freely and we heard staff talk about people's family life with them.

People were supported to make choices. We observed staff were kind and understanding and had a good empathy with people, encouraging independence but supporting as soon as was required. Staff offered advice and options to assist people in making decisions, as well as helping them to consider the impact on others. Staff were ready to accompany people when they wanted to go out, yet sought to encourage individual independence as far as was possible.

The provider had undertaken a restructure of staff which meant all staff would be a higher grade and able to become keyworkers. They would be key working one or two people which they told us would ensure

dedicated one to one time for every person living at Wilton Road. This restructure was underway and as such, a work in progress.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in September 2017 we found that not all care plans were up to date or reflected people's current needs. During this inspection we found the provider had made some improvement but not all support plans were fully completed. These were in a current stage of review and development and as such, a work in progress. Different methods of gathering information and creating support plans had been recently introduced. These included the 'recovery star' tool which looked at ten specific areas of life ranging from self-care to living skills. There were also person centred tools such as 'what is working', 'what is not working' and goal setting. The interim manager told us that the service was using different tools appropriate to the person. They said, "We have introduced a range of tools to promote creativity in the team. It's dynamic, building confidence and is intuitive not prescriptive. We are working with the person in the most appropriate way, 'where they are' at the time."

People could see health and social care professionals when required and were supported to attend appointments. These included, specialist diabetic screening services, speech and language therapists and dieticians. However, some of the monitoring guidance given by professionals such as mood charts, dietary intake and menu planner charts were not completed consistently. For example, one person needed encouragement to eat regularly due to recent weight loss and the action was to fill in a daily diet planner. This had been set up from the 10th of the month, but not completed by the 12th. Another person required a mood chart to be completed at regular intervals throughout the day but we saw gaps over several days. This meant that the monitoring methods of people's nutritional intake and mood levels were not effective.

The service was not fully compliant with the Accessible Information Standard. This is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We saw one person who had a sensory loss did not have access to specific equipment (visual aids) to support their disability and their care plan was not written in a large print format. The service had information from a disability support service but this was not integrated into the person's care plan.

People could follow their interests and engage in outside activities of their choice. For example, one person told us they enjoyed a visit to a bird sanctuary. They said, "I went to the birds of prey sanctuary and had a great time. They explained all about the different birds and I got this picture" and "I will be going to Beaulieu later this month to see the cars." Another person had attained their goals of visiting a stone circle, a football match and a music concert which they thoroughly enjoyed.

Another person was new to Wilton Road and had been gradually introduced to the routines by visiting and staying over to familiarise with new surroundings, the staff and other people. Their activity planner stated that they wanted to continue with hobbies and groups they already attended. It included a breakdown of practical everyday activities such as looking after their private space as well as dog walking and meeting friends.

People were encouraged to manage their own daily activities and be as independent as possible. We were

told that some people had the capacity to move on and find something more meaningful to do, others needed more encouragement. Outside groups and activities were encouraged but some people lost interest quickly or were not able to engage. One staff member told us, "We did a whole spate of evening activities, meditation, cooking, karaoke and there was pretty good interaction between people, they are supportive of each other."

'Residents meeting' notes showed they had been held mostly on a monthly basis. Items discussed at the last meeting in November 2018 included menu choices, the cleaning rota (people had specific household tasks) and evening group activities to be tried, such as quiz nights, meditation and cinema trips. It was noted that 'there is a willingness to try to do more together.'

Staff meetings followed a standardised format which included risk, outcomes (a review of good practice), learning and development, safety, medication and infection control. Areas to promote were involvement in group activities and a team discussion covering good news stories.

There was a system in place for recording and investigating any complaints which were raised. We saw there were no outstanding complaints.

We did not look at end of life care as no-one using the service was receiving this type of care at the time of our inspection.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2017 we found management quality monitoring systems were not fully established or embedded at Wilton Road. This had impacted on people's care plans, risk assessments and goals being out of date. During this inspection we found that further work was required. Monitoring and recording were completed inconsistently, care plan reviews and updates were in progress and some risk assessments did not reflect specific identified needs.

However, the interim manager had begun to develop new systems to audit and monitor the environment, care plans, medicines and the quality of care being provided. A daily checklist of 'staff responsibilities' included medicines administered and checked by two staff, reading the communication diary and daily checks of the building. Internal audits were undertaken quarterly by the provider.

There was a registered manager in post. However they were not present as they were now managing another home in the group. An interim manager was in place and was present throughout the inspection. A newly appointed registered manager who was undergoing the induction process with the interim manager, was also present.

The service had experienced several changes of manager in the past year. The staff we spoke with had found this difficult, one told us, "Lots of upheaval over last year, very difficult and frustrating, changes are suggested and then changed." However, they were positive about the recent management structure and changes being implemented by the provider, Rethink. This included, an integrated support system consisting of web based software to input and update information. The staff we spoke with also approved of the keyworker system and improvements being made to their qualifications and roles. One said, "This is what had been missing in the past, what we were trying to do as a company for people, a purpose."

Communication between the staff team was variable and some processes and procedures were inconsistent. For example, handover between shifts was given verbally and not written up. Although information was communicated it was not clear who was responsible for which action or whether each staff member knew all the relevant facts. One staff member had changed the safe place they kept the sharp knives overnight and it took some time to locate them. Some care plans had been reviewed and others were in process of being updated. The interim manager had also begun to develop a more person-centred method of recording support needs in the form of a 'what's working/not working and good day/bad day' assessment tool. Therefore, care plans were at different stages of completion. These new procedures needed time to be developed and embedded within the staff group.

The service worked in partnership with its landlord with regards to building and environmental improvements. Staff were currently responsible for undertaking emergency lighting checks; fire door checks and a monthly schedule was in place. During our inspection a fire drill was done which did not automatically close all the fire doors. This was rectified later when batteries were changed on the fire doors and automatic circuits were checked. These were new procedures and the interim manager told us that it would take time to upskill the staff and embed systems within the staff team.

The service worked very closely with the local community mental health team and had strong relationships with the psychiatric teams people used. This meant that the service could gain professional guidance and support when needed.