

Langley House Trust

House of St Martin

Inspection report

House Of St Martin
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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Requires Improvement ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

About the service:

The House of St Martin is part of the Langley Trust and is a residential care home. It provides accommodation and personal care for up to 31 people living at the House of St Martin. They also provide housing and tenancy services for men with multiple needs, mental health issues and substance misuse issues. The project consists of community houses within the local area. CQC only inspects services that deliver a regulated activity such as personal care, therefore we did not look at this project as part of the inspection.

The House of St Martin has gone through a big change since the last inspection in 2016. In 2018 the Home transitioned from a hostel for ex-offenders to a residential care home. The care home remains focused on working with ex-offenders but also supports men with multiple needs including substance misuse issues, mental health needs or a learning disability.

The management team have had to implement new ways of working since registering as a care home, and review the skills required for the new ways of working. Because of this the provider is reviewing referrals on a case by case basis. The provider told us this was to ensure staffing levels and skills meet the needs of people living in the home. At the time of the inspection 17 people lived at the home.

People's experience of using this service:

However, whilst the home was managed by a supportive and progressive management team who were clearly committed to improving the service, we did find areas of concern during the inspection that had not been improved in a timely manner. For example:

- Care plans were not always person centred and people did not have end of life plans in place.
- Staff were not always well trained with regards to managing people's physical healthcare needs and the provider had not made sure everyone had access to homes transport vehicle.
- People told us they felt safe living at The House of St Martin. People described staff as caring and kind towards them. Staff were approachable and friendly with people they cared for and knew them well.
- The house was homely and looked after, and we observed people engaging with each other in a supportive manner. Interactions between staff and people was respectful and we saw lots of banter which people seemed to enjoy.
- The grounds were extensive and the provider had plans to develop them so that people could learn new skills such as growing their own vegetables and creating outside areas where people can have personal

space.

- Where needed, staff were quick to support people to have access to health care professionals such as GPs, dentist and opticians or, when necessary, emergency services.
- People had their nutritional needs met. People told us they enjoyed the food and there was plenty of choice. People had access to drinks and snacks throughout the day.
- There were some restrictions placed on people as part of their release from prison. People told us staff were sensitive to these restrictions and did their best not to let them affect what people wanted to achieve.
- There was a house representative who attended national meetings with the provider. These meetings enabled people who lived at the House of St Martin to have a voice and feed in to policy and development at a national level.
- The management of risk to people was robust, and people's medicines were managed well. There was an outside contractor that came in everyday to manage infection control within the home and staff checked health and safety concerns, such as water outlets and fire equipment. The provider carried out robust quality assurance checks which had highlighted some of the concerns found during the inspection.

Rating at last inspection:

At the last inspection the service was rated as Good (September 2016).

Why we inspected:

This inspection was a scheduled inspection based on the previous rating

Follow up:

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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
Details are in our Safe findings below.

Good ●

Is the service effective?

The service was not always effective
Details are in our Effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring
Details are in our Caring findings below.

Good ●

Is the service responsive?

The service was responsive
Details are in our Responsive findings below.

Good ●

Is the service well-led?

The service was well-led
Details are in our Well-Led findings below.

Good ●

House of St Martin

Detailed findings

Background to this inspection

The inspection:

- We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

- This inspection was carried out by two Adult Social Care inspectors and one expert by experience who had experience of people living in care homes. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:

- House of St Martin is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

- There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

- The registered manager did not oversee the day to day running of the home. This was carried out by a project manager. The Registered manager told us, "The project manager is in the process of registering with CQC and will become the joint registered manager once their application is complete". For this report when we talk about the manager we will use the term, "Project Manager" as they are responsible for the day to day running of the home.

Notice of inspection:

- The inspection was unannounced on day one and announced on day two
- Inspection site visit activity started on 23 April 2019 and ended on 24 April 2019.

What we did:

- We reviewed the information we held about the service. This included the previous inspection report, notifications since the last inspection and feedback from the local authority. Notifications are changes, events and incidents that the service must inform us about. We used information the provider sent us in their Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
- During our inspection we spoke with the project manager, the training manager and the registered manager. We also spoke with seven care staff and 13 people who received personal care and support. We also received feedback from four health and social care professionals.
- We looked at records relevant to the management of the service. These included five care and support plans. We reviewed risk management plans, health and safety records, complaint and incident reports, four staff recruitment files, staff training records, medicine management records, and performance monitoring reports.
- Following the inspection, the provider sent CQC an action plan of how they intend to make further improvements in a timely manner, and evidence to confirm some actions have already been completed.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe living at The House of St Martin. One person said, "I wouldn't stay if I thought I wasn't safe". Another person said, "I feel safe here, I don't know anywhere else with better staff, staff have been great with me."
- People were protected from the risk of abuse because staff knew how to respond to, and report, any signs of abuse. One staff member said, "We complete a form and that goes to the manager who sends it to the senior managers and they inform the safeguarding team". One staff member did say, "We don't get to know the outcome of the alerts, that would be good to follow it up". The project manager told us they would look at how this can be improved.
- The project manager understood their responsibilities to raise concerns and record safety incidents and report these internally and externally as necessary.

Assessing risk, safety monitoring and management

- Risks to people and others were minimised because clear risk assessments were in place. For example, one person had a risk assessment regarding a specific behaviour which may place them at risk. The risk assessment identified the triggers for the behaviour. It also provided guidance that could help staff to minimise the risks.
- Risks to people's health and well-being were assessed and control measures were put in place to minimise these risks. For example, one person had been assessed as being at high risk of falls and equipment and supervision needed was recorded.
- Environmental risks were managed. For example, fire maintenance and safe use of water outlets. We reviewed the provider's business contingency plan that ensured the service would continue if an emergency happened. The provider had contractors that serviced equipment to ensure it was safe to use.
- Care plans included a personal emergency evacuation plan (PEEP) for each person. A PEEP sets out the specific physical and communication requirements that each person had to ensure that they could be safely evacuated in the event of an emergency.
- Some people had times when they could become unsettled or distressed. There was guidance in people's records on what action staff should take to support them at such times. Staff told us, "(Persons name) can

get really anxious and we spend a lot of time reassuring them, we go for a smoke with them and walk around the ground that helps calm them down".

Staffing and recruitment

- Safe recruitment processes were completed to ensure staff were suitable for the role. This included employment checks and a Disclosure and Barring Service check (DBS).
- The service deployed sufficient suitable staff to meet people's needs. The home had seven staff night time vacancies which had been filled with agency staff. The project manager told us the agency staff were regular staff, which meant people had consistency in care and support staff.
- The project manager produced a staff rota in advance. The rota confirmed shifts were covered as required. Although, staff, people and professionals all said the home would benefit from additional staff because people had such high needs.
- One professional said, "If the home takes any more people in I would be concerned about the staffing levels". Staff told us, "We don't always get to do much with people because personal care needs are quite high so more staff would help." The project manager told us, "We have identified the staffing concerns and have now put managers on at weekends and will be overstaffing days to make sure we have plenty of cover when staff are absent."

Using medicines safely

- People received their medicines safely from staff who had received training to carry out the task and had had their competency assessed.
- The provider had systems to audit medicine stocks and monitor the effectiveness of prescribed medicines.
- Records were kept of all medicines coming into the home and when they were administered or refused. Weekly audits of medication administration records and stock were carried out.
- Where medicines required additional security, and recording this was carried out. We checked a sample of these and found stocks held correlated with records kept.
- One care plan showed a person had wished to take control of their own medicines, but the risk assessment showed this would place them at risk. Following discussions with the person they had agreed for staff to administer their medicines.
- Where people were assessed as safe to self-medicate, medication administration records showed the quantity of medicines which had been given to them. This enabled staff to monitor how people were managing their medicines.

Preventing and controlling infection

- Staff understood their responsibilities with regards to infection control and keeping people safe. The provider hired a cleaning company to come in daily and there was a cleaning schedule for the kitchen which staff were aware of and completed daily.

- There were hand washing facilities throughout the home. Staff had access to personal protective equipment (PPE) such as disposable gloves and aprons.

Learning lessons when things go wrong

- Lessons were learned when things went wrong so that improvements could be made to the service to keep people safe. For example, one person's behaviour could become challenging and would only change when the project manager interacted with them. The project manager told us, "Staff brought this to my attention and we had a problem-solving session." Adding, "We agreed in future anything this person requested would go through staff." This person now responds well to all staff.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs and choices were assessed. Assessments assisted staff to develop care plans for the person and deliver care in line with current legislation, standards, and guidance. However, treatment and support was not always provided to meet people's needs.
- People had care plans but they focussed on the risks people posed to themselves and others rather than all aspects of person centred care. For example, where people were at risk of self-harm, there was a clear management plan in place for this. Also, where people could pose a risk to others this was recorded and there was evidence that control measures had been agreed with other professionals.
- There was not clear guidance around people preferences, for example people did not have a personal hygiene plans in place, although people did say they told staff how they wanted to be helped. One person said, "I can say what I need and staff do it for me".
- The provider did not always consider how barriers due to disability impacted on people's ability to access the community. For example, the home had a mini bus but it did not have wheelchair access. Three people who used wheelchairs told us that this prevented them from using this transport, although alternative arrangements were made.
- We discussed this with the project manager who told us, "We have identified this as an issue and we are planning to purchase an additional vehicle that is fully wheelchair accessible". Following the inspection, the provider sent confirmation that they had purchased a wheelchair accessible vehicle.

Staff support: induction, training, skills and experience

- People were supported by staff who told us they had received a good induction when they began work. One member of staff said, "The induction was good. I did some shadow shifts too." This helped to make sure staff had the basic skills needed to provide safe support to people. Other staff told us, "We get mandatory training, such as safeguarding and health and safety".
- Since the last inspection the home had increased in size and begun to support people with increased personal care and health needs. Staff had received additional training to accommodate these needs, such as moving and handling. However, most staff felt they would benefit from further training in care and

support. For example, staff had not received training in end of life care or epilepsy even though people living at the home had needs in both areas. One staff member said, "I didn't even know what palliative care meant".

- The project manager told us, they had been working closely with the provider's training manager to identify where there were gaps in staff knowledge and what they needed to do to bridge the gap. For example, the provider had contacted the local hospice to deliver some end of life training for staff.

- The provider also recruited new staff with care and support experience to ensure staff that had come across from the hostel had peer support and mentors they could learn from. One staff member told us, "We are learning from each other."

We recommend the provider review their training needs and ensure they remain in line with national guidance and legislation.

- The provider carried out supervision and appraisals with staff to discuss their work and training needs. The provider said this was an area that needed to be strengthened. "The project manager told us, "Staff haven't had regular one to one supervision, we need to be better at it, and we will". Staff told us they could speak to the manager any time. "One staff member said, "We have a debrief at the end of the team meetings where we can talk about anything we need to".

Supporting people to eat and drink enough to maintain a balanced diet

- People were provided with food that was well presented and plentiful. On the day of the inspection people appeared to enjoy the food served at lunchtime.

- People did not routinely have their nutritional needs assessed and there were no individual care plans regarding supporting people with food and drink. However, most people could make their dietary needs known and express their preferences. The project manager told us they would make sure nutritional plans are in place for everyone living at The House of St Martin.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's healthcare needs were not always fully assessed, and care plans did not give full guidance to help staff to promote people's health and well-being. For example, one person had diabetes and the care plan stated staff should help the person to monitor their blood sugar levels. Although staff were recording the person's blood sugar levels twice daily, there was no information about what the person's normal range should be. Therefore, there was no information about what action staff should take if they were outside normal range or appeared unwell.

- Where people had epilepsy, there was no care plan in place to state if people required additional supervision, the type of seizure the person may experience or what action staff needed to take if the person had a seizure.

- There was not always clear information about the equipment people required to promote their health. For example, one person had a pressure relieving mattress on their bed but there was no care plan in place to show the rationale for this. There was no information about how staff should maintain the mattress or monitor its effectiveness.

- People were supported to attend appointments with healthcare professionals outside the home. Care records showed people had access to professionals including; GP's, dentists and chiropodists.

Adapting service, design, decoration to meet people's needs

- The building was the original old building with a purpose-built extension attached. It was nicely decorated and homely. People were encouraged to personalise their rooms and everyone had a key to their own room. One person told us, "Spotless, all my stuff is here, got everything you want in this place." There was access to outside space and quiet areas for people to receive visitors.

- Some doorways in the old part of the building were not wide and some people who used a wheelchair struggled to get through them. One person showed us how they had to manoeuvre their wheelchair to get through. We asked this person if this was a problem, they told us, "I've been asking for the door to be widened but I can access the rest of the home fine, it's just the doorway". The project manager told us, "The home was fully accessible, but they would discuss widening these door ways with the maintenance team".

Ensuring consent to care and treatment in line with law and guidance

- 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).

- Staff did not always make sure people were supported in the least restrictive way. For example, one person's care plan showed they often slipped out of their bed. In response to this the provider was planning to fit their bed with bedrails and the person had given their consent to this. However, there was no evidence that other less restrictive options had been discussed with the person. The project manager told us they would review restrictive practice in the home and adjust people's care and support in line with best practice.

- Most people could make decisions and choices about their day to day care and support. Where people could not make decisions, the staff knew about the principles of the MCA and said they would discuss with managers if a best interests decision was needed.

- One person had a DoLS authorisation. The care plan showed this had been fully discussed with the person. Staff spoken with were aware of the restrictions this placed on the person.

- Where restrictions were placed on people as part of their release from prison conditions these were recorded in care plans and staff were aware of them.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- We observed motivated staff who offered care and support that was compassionate and kind. Staff demonstrated respect for people they cared for. One person told us, "Staff here help us in every way." Another person said, "Staff are really kind they look out for us".
- The provider focused on building and maintaining open and honest relationships with people. Staff were matched with people's interests and personalities. One person said, "It's the best place I've been in." Another person said, "It should win an award this place as it's great."
- Staff respected people's cultural and spiritual needs. The project manager told us, "We are a Christian based organisation, but we have people here from all faiths." And, "We have a volunteer Chaplain who comes once a week". The project manager also told us, "We have people who need quiet time and we are planning to develop a Japanese garden so people can meditate". One person told us, "I had to attend church with staff at first but with their support I can now go on my own".
- Training records showed that all staff had received training in equality and diversity.

Supporting people to express their views and be involved in making decisions about their care

- People felt involved in decisions about their care and told us they could express their views about how their care was delivered. One person told us, "Yes I know my care plan, I set goals with staff to help me budget". Another person said, "I have a care plan, I'm involved in everything". Two people we spoke with said they had been included in their care but they did not recall seeing any care plans. We discussed this with the project manager who told us, "We don't give people copies of the care plan but they can have it if they ask for it".
- All staff positively welcomed the involvement of advocates to support people to make decisions based on their own preferences. For example, one person was currently working with the independent mental capacity advocate (IMCA) to help them understand why they could not leave the building due to their authorised Deprivation of Liberty Safeguard. and were on a DoLS

Respecting and promoting people's privacy, dignity and independence

- Staff respected people's privacy and dignity. All staff we spoke with could tell us how to protect people's

dignity when supporting people with personal care. One staff member said, "I make sure people have their privacy, especially if I'm helping them wash". People told us, "They knock on the bedroom door if they want to go in". And, "Yes, I need help to shower, staff are good with me". Another person said, "Yeah staff are alright they're very good." People were supported to be independent, for example one person told us, "Staff are helping me look for a flat, they help me do things like cook and clean my room."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People received care which was personalised to them because staff knew people well and respected their wishes where appropriate. Care plans would benefit from being more person centred so that new staff had clear guidance on how to meet people's needs. "One member of staff told us, "The changes are really quite exciting". Adding "We are learning about people's individual needs." Other staff said, "I'm not used to care work, I'm from the hostel days, but its good learning new ways of working".
- During the inspection we saw people followed their own routines. People made choices about what time they got up and how they spent their day within the limits of any legal restrictions placed on them.
- People had contracts which set out any house rules which they needed to abide by to maintain their place at the home. People had signed these contracts and were aware of the legal restrictions in place.
- There were some organised activities for people, and people could do their own thing if they preferred. For example, one person like to catch the bus in to town and one person liked to attend church services. Other people liked to play music. One person said, "We do lots of crafts with staff".
- One staff member was passionate about ensuring people had fulfilling lives and wanted to do more of the activities in the home. This staff member told us, "I tend to start something and see who feels like joining in". Adding, "Some things we do are not appropriate because we have a mixed age range". The provider told us they had plans to develop the land around the home and create some gardening projects in the future.

Improving care quality in response to complaints or concerns

- The service had a complaints system in place; this captured the nature of complaints, steps taken to resolve these and the outcome. At the time of the inspection there were no live complaints.
- The registered manager told us, "people are vocal if they don't like something they will tell us and we sort it as soon as possible.
- People told us they knew how to raise concerns and make complaints. The local complaints procedure was available in the communal area. One person told us, "I would definitely tell them if I was unhappy". Another person said, "Oh yes, I will soon let staff know".

End of life care and support

- End of life support had been considered by the provider as they told us they wanted to apply for the gold standards framework. However, this was a longer-term goal. At the time of the inspection we found people did not have end of life care plans in place and two people living at the home had a terminal illness.
- These people did not currently need end of life care but staff were concerned that they had not received end of life training to support them if their health deteriorated. One staff member said, "We don't know how to look after someone with those sort of needs".
- The project manager told us people living at the home had capacity to tell staff what they wanted should they require end of life care, but understood they needed to put care plans in place.
- On the day of the inspection the provider contacted the local hospice and arranged for specialist staff to deliver some training to staff. They also assured us they would implement end of life care plans for everyone living at the home. The project manager told us, "We want people to be here for life so we will make sure we have the skills".

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- Staff, people, and professionals were positive about the project manager at The House of St Martin. People told us, "Yea (manager's name) is a good bloke". And "They help me a lot, and we have a joke".

- Staff comments include, "(Managers name) is really supportive when they are here". And, we get support from (managers name) but we need them here more often". One professional told us, (Managers name) is very good but spread too thin". Adding, "The provider needs to make sure they are more accessible."

- We discussed this with the project manager who told us, "We are aware we need a stronger management presence which is why we have recruited a compliance manager". They told us, "This new post starts in May 2019".

- The registered manager understood the requirements of duty of candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The provider and the project manager demonstrated a commitment to ensuring the service was safe. Quality monitoring systems were in place and checks were regular. The provider had identified issues that needed to be addressed such as additional training for staff, and better physical healthcare support. Improvement plans were in place but the provider did need to review their priorities and ensure these were actioned in a timelier manner.

There were systems in place to safeguard and protect staff. There was a lone working policy in place and staff said they could contact the project manager at any time and they would respond. One staff member said, "There is an on call as well when managers aren't here we use that".

- The project manager and staff were clear about their roles and responsibilities. Regular manager and staff meetings took place where improvements and learning were shared.

- Staff told us they felt supported, valued and listened to by the project manager, but not fully supported by the rest of the management team. A staff member told us, "When (managers name) is not here we have to work things out for ourselves". Another staff member said, "Because it's a new way of working we need lots of support and that's only there when (managers name) is here". The project manager told us this was being addressed by recruiting a compliance manager who starts in May 2019 and reviewing the current management structure of the home.

- The registered manager communicated all relevant incidents or concerns both internally to the provider and externally to the local authority or CQC as required by law.

Working in partnership with others

- Staff worked in partnership with other agencies to provide good care and treatment to people. Professionals feedback was mostly positive about partnership working with the home. Some professionals were concerned that if the home took in any more people they may not be able to manage the high level of needs for people living at The House of St Martin.

- The manager assured us they did not plan to take any more referrals until the staff team had developed their skills and the provider felt confident people's needs would be met safely.

- The service had good links with the local community and key organisations such as the community mental health teams and probation services.