The Society of St James

St James Care

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This inspection was unannounced. When we last inspected the service on 01November 2013 we had found they were in breach of regulation 12, cleanliness and infection control. The provider produced an action plan to show how they intended to improve the service. At this inspection we confirmed that the actions the provider told us they would take to address these concerns had been actioned. St James Care is a registered care home specialising in care for people with mental health issues associated with alcohol dependency. The Society of St James provides support for people to manage their alcohol dependency safely when they do drink and support for people who are homeless. The service provides accommodation and personal care for up to 15 older persons over the age of 50. Due to tragic unforeseen

Summary of findings

circumstance there is currently no registered manager in place. An acting manager had been appointed and a permanent manager had just been appointed. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Staff understood the needs of the people they supported. They told us how they encouraged and enabled people to be as independent as they could be. People were able to contribute to their care planning. Staff were aware of people's preferences and encouraged them to make choices when possible. Staff spoke with people in a caring, compassionate way and were attentive to people's needs. People told us they got on well with staff and felt they were treated well. Where people did not have the capacity to make particular choices, meetings were held to agree decisions made were in the person's best interest.

Staff received appropriate checks prior to working with people to ensure they were suitable. They received a comprehensive induction and had access to a wide range of training events. They received regular supervisions and support where they could discuss their training and development needs. The provider had appropriate recruitment processes and made sure staff were trained and supported to deliver care required.

People were able to manage their alcohol intake in a safe and monitored way by drinking within the service. They were involved in agreeing the amount and the strength of the alcohol they drank. This meant people did not go into withdrawal or become too intoxicated. Health professionals were available to support people with their dependency.

People's changes to their care and support needs were recorded in their personalised care plans. They were able to contribute to discussions around their care and could change make changes to their care plans by talking to staff. The provider asked people for their opinions on the quality of care they received and responded to comments and complaints received in a timely and appropriate manner.

There were appropriate management arrangements in place and staff and people told us they had no problems in talking to managers about any concerns. People were actively involved in developing the service through regular meetings with staff and the provider. Regular audits of the quality of the service were carried out to ensure the safety and welfare of people. There were sufficient numbers of staff to meet the needs of people.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff had received training in identifying and reporting abuse and knew their responsibility in keeping people safe. They were aware of who they needed to report concerns to.

Risks associated with maintaining people's dependence on alcohol were being managed. This was in agreement with each person and gave them a safe environment in which to carry on this activity. People had access to health professionals to support them with their addictions.

Where people did not have the capacity to make decisions, mental capacity assessments were carried out. Deprivation of Liberty orders were in place for two people. Staff knew how to support the people to maintain their safety.

The provider and team leader arranged staff rotas based on the support needs of people. This made sure appropriate numbers of staff were available to support people as they needed.

Is the service effective?

Good

The service was effective.

Staff received training to support people's individual needs and the management of their mental health conditions. Staff were aware of agreements in place around alcohol management for each individual.

People were supported to access health professionals and treatments. A local GP would visit people when required. The provider worked closely with local mental health professionals to review people's medications and their mental health needs.

People received sufficient food and drink and had choice over what to eat.

Is the service caring?

Good

The service was caring. People told us they got on well with staff and said they were all very caring. We observed people were at ease with staff and were engaged in friendly conversations. Staff spoke with people in a caring and compassionate way.

People were involved in their care and could talk to staff about changes to their care. A personalised care plan ensured staff were aware of people's preferences and choices.

Staff showed their understanding of people's physical and mental health conditions. Each person knew who their key worker was and told us they had regular meetings with them to discuss their care plans.

Is the service responsive?

Good

The service was responsive. A personalised care approach was used and people were involved in assessing and identifying their needs. This was regularly reviewed in monthly keyworker meetings.

There was a range of activities for people to participate in based on their personal interests and hobbies. People accessed the community on their own and were encouraged to be independent.

Summary of findings

People had made comments about the service in meetings with their care workers. The comments were passed on to the manager and provider. People told us changes had been made to aspects of the service such as decoration of a communal area.

Is the service well-led?

Good

The service was well-led. Arrangements were in place to help ensure the effective management of the service until a new manager commenced.

Staff received regular supervisions and spoke highly of the support they received from the team leader and the provider. Staff told us they could talk to the provider or team leader whenever they needed to.

The managers monitored incidents and risks to ensure the care provided was safe and effective. People's opinions on the service they received were asked for through questionnaires and key worker meetings. People told us they could talk to managers whenever they needed to.

St James Care

Detailed findings

Background to this inspection

We inspected St James Care on 09 July 2014. The inspection team consisted of an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in substance and alcohol misuse.

We used the information that the provider had given us on the day of our inspection through completing a Provider Information Return. 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 used this information to support what we found on the day of our inspection. We looked at notifications received from the provider which is information about important events which the service is required to send us by law.

We spoke with six people who used the service and looked at care records and support plans for four people. We spoke with six members of staff, one relative and a visiting professional. We looked at the records of four members of staff. We observed people being supported by staff throughout the course of our inspection. We pathway tracked one individual which meant we spoke with the person, looked at their care records and spoke with their relative.

The Society of St James is a registered charity who have been helping homeless people in Southampton for over 40 years. They began as a group of volunteers from a collection of churches who opened up a church hall to accommodate a group of homeless men. They state their philosophy as: “We believe that everyone has a right to a home. We believe that people should be given the opportunity to develop the skills they need to lead a fulfilling life. We believe that everyone deserves not just a second chance, or a third chance, but as many chances as they need to change their lives for the better.”

Is the service safe?

Our findings

There were procedures in place to ensure people were supported by staff who knew how to report concerns appropriately. All people told us they felt safe and said they could talk to staff if they needed to. However one person told us, "I still don't feel safe as someone who used to be a resident and has moved on now, used to display behaviour which I found threatening. Staff have told me they won't be coming back but I still feel worried." Staff told us they were aware of this person's concerns and would spend time reassuring the person when they saw they were anxious. Another person told us, "I do feel safe; I have a buzzer in my room in case I need help."

Staff knew how to recognise abuse and who they would report this to. Training records noted that all staff had attended a safeguarding vulnerable adult's course within the last year. This was in line with the Hampshire, Southampton, Portsmouth and Isle of Wight's Councils Safeguarding Policy. Staff said they received an annual update on this training as well. They also received training in the specific needs of people who lived within the service such as mental illness, dementia and alcohol dependency. Staff had sufficient knowledge to support people safely in relation to their identified needs. One person's care records showed where a safeguarding concern had been addressed. Due to risks identified and the person not having the capacity to manage their financial affairs, a court appointed trustee managed this for them.

Many of the people were dependent drinkers and received support around the management of their alcohol intake. We saw in the care records each person had an agreement in place to support them to drink alcohol at safe levels. This included peoples individual supply of alcohol being controlling the supplied by staff. This arrangement had been discussed with the individuals and they had agreed to this management of alcohol as part of their alcohol reduction programme and agreement to live in the service. This helped to make sure that people did not go into withdrawal whilst stopping them from becoming too intoxicated. It also meant the strength of alcohol was at a lower level than if purchased externally. This allowed people to drink controlled amounts of alcohol in a safe environment.

The front door was not locked and people were able to come and go as they pleased. We observed one person telling a member of staff they wanted to go out into town for some shopping. We looked at the person's care records and saw there was a risk assessment for this activity, which the person had signed. This had been reviewed in July 2014 with no amendments required. As part of the alcohol agreement in place, people had agreed not to bring alcohol into the building. We observed the person on their return showing staff the contents of their bag and saying they had not bought any alcohol. These agreed arrangements helped to make sure the person and others living at the home were not put at risk.

There was a robust process for identifying risk for people. Activities people were engaged in were assessed for risks. Staff and people identified how they could minimise the risk and agreed actions were put in place. Systems were put in place so that people could continue to engage in activities outside of the home with the minimum amount of staff support they required. For example two people went out together without staff support. We saw in their care files there were care plans and risk assessments in place which gave staff guidance on assisting them to go out. They agreed with staff what time they would return and what time they wanted their lunch when they returned.

Where people did not have the capacity to make decisions mental capacity assessments had been carried out to determine their level of understanding, retaining information and communicating their choice. The provider told us of two people who were subject to a Deprivation of Liberties Safeguards (DoLS) order. This was where the Court of Protection detailed restrictions to people's liberties, rights and choices in order to protect them from harm or abuse. People were able to come and go without restriction as the front door was not locked. Where people required support to access the local community they were able to ask staff to support them to do this.

The provider was aware of recent changes in legislation about DoLS which could have an impact on all people in the service. They told us they were working with local mental health professionals to assess each person and then agree if a DoLS application would be appropriate for people.

There was an effective system to ensure the staffing numbers were sufficient to provide the amount of support people required. People told us there were always enough staff on duty to help them. There were suitable arrangements in place to cover shifts with relief or part time

Is the service safe?

staff when required. We observed there were five staff on duty who all performed their designated tasks. We spoke with bank staff who covered day and night shifts when permanent staff were unavailable. They told us how important it was for people to have staff that were familiar to them to support them. We looked at duty rotas and saw all shifts were carried out by permanent or bank staff. The provider showed us how they had worked out the number of staff required to support people which was based on people's identified needs and the identified hours of support they required. They told us they would change the levels of staff if people's needs changed and they required more support. This was reviewed within the provider's regular audits.

There was a robust recruitment process which ensured staff were safe to work with vulnerable people. This involved completing an application for a criminal records check. There were copies of criminal record checks in staff records. Each member of staff had two professional references in their files. Staff completed an induction process before working with people. Staff completed an in depth induction training using the Skills for Care nationally approved induction standards.

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Is the service effective?

Our findings

One person told us, "the staff know how to support me and have helped me a lot." Another person told us "I am aware that staff go on training so that they can help all of us a lot better. It certainly helps knowing I can talk to them about my problems and they understand what that means to me." We spoke with a member of staff who told us, "We get a lot of training and I have asked to do more on dementia so that I can understand how it could affect people here". People told us they were happy with the food choices and meals they received. One person said, "The food is okay, they always offer me an alternative if I don't like what's on the menu." Another person said, "If I need to see the doctor then I am supported by staff to make my own appointment. If I want staff to go with me that is my choice."

The service had been in breach of regulation 12, cleanliness and infection control on our last inspection on 01November 2013. The provider had told us the action they would take to meet the regulation. All staff had received training in infection control and safe systems to carry laundry to the laundry room had been put in place. A new industrial washing machine and tumble drier had been installed in this room and the room had been re-decorated. Whilst sufficient progress had been made to meet the regulation, a new sink was immanently about to be installed.

Staff undertook a wide range of training events in order to gain knowledge and insight of the support needs of the people such as mental health awareness, dementia, alcohol and substance abuse and mental capacity. A bank support worker, who was employed to provide cover for staff vacancies, holidays and sickness, told us, "I have attended a lot of the training permanent staff do. It has been really helpful as I understand the people a lot better now. Another member of staff said, "the managing of challenging behaviours training was excellent and I used this to defuse the situation and help the person to keep calm." Staff received regular supervisions where they were able to discuss with their line managers aspects of the care people received and also receive feedback on their performance. Staff received an annual appraisal which identified their development and training needs and set personal objectives for staff to achieve.

Meals were all planned on weekly menus and people could make a choice between two options for their meal. The kitchen manager was aware of people's needs and showed us a list of likes and dislikes for all people. People's options were based around foods they were known to like. Kitchen staff were aware of people who required a diabetic diet and provided a range of food and drinks suitable for them. People were involved in the planning of each weekly menu and these could be changed to meet individual choices. Records were maintained of food intake for people who required this due to risk of malnutrition. There were flexible arrangements for people around when they chose to eat their meals. One person returned to the service at lunch-time, after being out for the morning. They chose to eat their meal later on in the afternoon and the kitchen manager prepared something for them.

Care records contained a section concerning physical and mental health. Identified needs were included in people's care plans and risk assessments. For example one person had a diagnosis of epilepsy and there were guidelines for staff on managing the person's epilepsy and emergency treatment they required should they have a seizure. A GP visited the service and all people were registered with the local surgery. Staff encouraged people to make their own appointments and were available to support people to attend if they wanted support. We saw a psychiatrist undertaking a medication review for one person. The person was present for the review and was supported by staff to inform the psychiatrist of their wishes.

A number of people were dependent on the use of alcohol and cigarettes. Each person had an agreement with the service as to how much they drank and smoked. Part of this agreement was for the service to manage this with the person in order to maintain their health and to manage their finances. One person told us, "I know if they didn't look after my booze and fags I would just drink and smoke the lot in one day. Then I would have to go out and beg or steal more." Another person told us, "I know it's not good for me but I just can't give it up." A visiting health professional told us. "We work with the service to monitor people's health as we know how hard it is for people to give up their alcohol. The agreement helps to ensure people are able to drink safely."

Is the service caring?

Our findings

One person said, “I do get on well with staff and they are always pleasant to me.” Another person told us, “I would describe my relationships with staff as good; I get on with everyone here. One person told us, “The staff here are very caring and very busy. They always find time to have a chat though.” One person said. “I find staff to be very helpful and they always make sure I am okay. If I need to see the doctor they always help me to book an appointment.”

People were involved in their assessment or care planning processes. One person said, “I do have a care plan but I didn’t want to be involved in it.” Another person said they had a care plan but did not tell us what this meant to them. One person said, “I do have a care plan and I can change things when I talk to my keyworker in my key working session”. A key worker is a member of staff who has lead responsibility for a person, their care and their care plan. We saw records of keyworker meetings in people’s care records. These showed people had discussed aspects of their care with staff and some actions had been identified to change the person’s care plan. Changes made to care plans were dated and signed by the person and the team leader.

Care records showed each person had an assessment of their needs. These assessments contained essential information each person had identified as important for staff to know in order to support them. We saw an outcome from a key working session had been incorporated into the person’s care plan. This meant some people had been involved in writing their care plans and could make changes if they required them. For example one person had requested in their key working session to return to their country of birth. The service had discussed this with the person and their care manager and plans were in place to proceed with this.

People were cared for in a dignified way because of the way staff interacted with them. We observed staff knocking on people’s doors and waiting for them to respond before entering the room. A person asked to speak to a member of staff and the member of staff asked them if they wanted to do this privately. They went out into the garden where they could be private. Staff spoke with people in a caring and compassionate way, asking them what they would like or what they wanted to do. We saw people were engaged in conversations with staff and making jokes with them. People were addressed by their preferred names and this was evidenced in people’s care records. Staff were knowledgeable of people’s health needs and care plans. Staff understood people’s needs around their alcohol dependency and had arrangements in place as to where people preferred to drink, either in the lounge or in their own rooms.

We spoke with one person who had been living in the service prior to it being purchased by the current provider. This was when the building had been used as a care home for older persons. They had been asked if they wanted to move to another home but told us they chose to stay. They said, “I am so happy here and although I don’t understand why people like to drink, they all treat me with respect.” The person’s care records showed how they had been involved in the decision to stay and risk assessments were in place to maintain the person’s safety.

The provider told us they had appointed a member of staff to act as the service’s dignity champion. A dignity champion should challenge poor care practice, act as a role model and educate and inform staff working with them. They had completed an audit of how people’s rights were respected by staff. This had been discussed with staff in the staff meeting and had led to staff looking at how they supported people’s rights. One member of staff said, “I think people have the right to go out and enjoy helping them to find things to do.” The dignity champion attended a local authority meeting for dignity champions where they shared ideas and best practices with other care homes. This meant they had been able to gather information about how other services supported dignity of people. The provider told us they were meeting with the dignity champion and looking at how they could use the information to improve how they supported people.

Is the service responsive?

Our findings

People told us about their experiences of how the service responded to comments or requests they had made. One person said, "I spoke to my key-worker about cleaning my room and not wanting to do it. We spoke with the team leader and agreed that I would remove dirty plates and cups and the cleaner would hoover and dust. I was happy with that." Another person told us. "The staff always listen to you and I know if I have a problem they will help me sort it out." A person said, "They (the provider) always make time to speak with me if I need to ask them about something." One person told us, "I enjoy going to the (local authority support) group as I have made friends there and look forward to seeing them."

The provider told us how they managed difficult situations concerning maintaining positive relationships for people with their relatives. These would involve discussions with the family, social workers and the police if necessary. They said solutions would be found which enabled the person to continue to see their relative which was acceptable to all parties. The provider acknowledged these could be difficult to resolve and extra support could be offered to the person. They would use an advocate to support the person through this process and ensure their views were sought.

The provider was responsive in finding out what was important to people by using a personalised care plan. People told us they had been involved in this process and had told staff what they liked or disliked in a number of areas. For example one person continued with their choice to drink alcohol. Their care plan showed they had agreed a limit to the amount of alcohol they drank each day. Staff had reported the person was suffering more falls due to their intoxicated state. Advice and support were made available to the person but they told us they did not want to listen to the professionals. A meeting was held, involving health professionals, the person, staff from the service and an advocate. As the person did not have the capacity to understand fully the heath risk of continued drinking a decision around supporting them needed to be made in their best interest. The meeting agreed to support the person to continue as they wished and arranged for extra monitoring of the person's health through their GP.

Everyone had weekly activity timetables which identified social, educational and occupational opportunities for people. These were matched to their interests. The provider told us this was an area they were looking at increasing in the future as they had found if people were occupied their use of alcohol decreased. They had already seen positive changes in people's behaviour and well-being when they were engaged in activities that occupied them. For example one person had begun to go out sea angling every week, as it was an interest staff had introduced for people to try. They really looked forward to this and had formed a friendship with one of the crew on the boat. This had led to the person choosing to reduce their alcohol consumption as they wanted to do other things. People had been attending local authority support groups and social groups. The Society of St James also ran a community drop in support service which some people from the service accessed.

People were able to go out independently if they wished and some people accompanied each other when they went out. We saw people accessing the community independently throughout the day of our inspection. One person returned to the service and spoke with us about where they had been and showed us what they had bought when they were in town shopping. They said, "I was going to go to the pub but realised I wouldn't have had enough money to buy what I wanted." The person told us they had used their own mobility scooter to make the journey. This showed how people were able to maintain links within their local community and how they were able to do this independently.

There was a comments and complaints book for people to write in if they needed to. Staff told us they checked the book on a daily basis. Comments left were responded to by the provider and manager which were recorded in the book. People told us they would speak to the manager or the provider if they needed to make a comment in private. Staff told us they used to hold a three-monthly consultation meeting where people could talk about concerns or bring forward suggestions for improvements to the service. This had not occurred since January 2014 due to disruptions in the meeting. Instead people had agreed they would prefer to raise any concerns in their monthly one to one meetings with their key-worker. There was a complaints procedure in place which was displayed in communal areas of the building and all people had copies of this in their rooms. The provider told us about the last

Is the service responsive?

complaint received and told us how they had responded to this. The provider told us how they had resolved the complaint and we saw a letter from the complainant stating they were pleased with the outcome.

Care records included details about their wishes regarding end of life. We noticed two people had not completed this section. The provider told us this had been by their choice as they found it difficult to talk about this. Staff told us they were talking to people within their key worker sessions to find out any preferences or choices. The provider told us they were supporting a person who had been diagnosed as requiring end of life support. This led to the service reviewing their policies and procedures and providing more training for staff in end of life care. The person identified they wished to be cared for within the service if possible and had planned aspects of their funeral.

Is the service well-led?

Our findings

Due to tragic unforeseen circumstances there has been no registered manager since the beginning of 2014. There were clear management arrangements in place during this time which included an acting manager being appointed and a permanent manager had just been appointed and was due to imminently start. The operations manager for the provider had assumed overall responsibility for the service and was based in the service for the majority of their time.

One person told us, "I miss the previous manager but I know I can talk to the team leader or provider if I need to." Another person said, "It had been a difficult time but staff and the provider had helped everyone through it." One person said, "Staff always keep us up to date on what is happening and we can talk about changes before they happen." A relative said, "The staff always know what they are doing and are well managed." A professional told us "It is clear to see who is in charge and staff follow directions we give to the provider and senior staff." People were aware of who the acting manager was and told us they were aware that a new manager would be starting soon.

We spoke with a visiting professional who had been attending a meeting in the service. They told us the person they supported received a good quality of care. Staff spoke with the professional and the acting manager told us about how they involved visiting professionals. The provider said they enjoyed good relationships with health and social care professionals and made sure they were involved in decisions about people's care whenever possible.

Staff told us they were aware of the service's philosophy and values as this had been explained to them during their induction programme. One staff member said, "It's a great place to work. I feel totally involved in the planning of care for my key-person. I can make comments about the person's care and know that I am being listened to by the manager and provider." This was also something we were told by a person who said, "If I want to change anything in my care plan I can talk to my keyworker and then the acting manager will talk to me and show me if the changes have been agreed."

Staff said they were aware of the provider's whistle blowing policy and they would have no hesitation in using it if they needed to. One member of staff said, "I would have no hesitation about talking to the provider if I had a concern. I know they would listen to me and act on what I tell them."

The management arrangements ensured staff were still receiving supervisions and support despite there being no registered manager. Staff records showed these had been happening every six to eight weeks for all staff. Appraisals had also occurred during this period and staff had been able to identify training they required. The provider showed us the system they used to monitor when staff had attended training and when they needed to attend an update or new training.

The provider and manager carried out regular audits of the quality of the service. These included audits of medicine management, care records, health & safety checks and maintenance of the environment. An action plan, following one of these audits, highlighted people might enjoy activities outside of the home which may have a therapeutic benefit if they were engaged and not drinking alcohol. This was discussed with staff and people and ideas for group and individual activities were asked for. One activity identified was going out on a boat for sea fishing. The team leader carried out a risk assessment for the person who wanted to do this. This became a regular monthly activity which the person enjoys.

The provider shared with us how they would like to develop the service. They had noticed how some people had responded to being involved in receiving more regular activities. People had asked for some help with their alcohol dependency. There were posters and pamphlets available for people about services that could support them to stop drinking alcohol.

Records for incidents and accidents showed staff had recorded these when they occurred and they had been seen by senior staff within the team. Responses were recorded and information was collated for a monthly report. A record of an incident had been investigated by the provider. New guidelines had been produced following this incident which helped staff to support the person better. The provider responded to incidents and changes were made to improve the support people received.

The provider carried out a survey of the quality of the service in December 2013. This had been completed by

Is the service well-led?

people to reflect their opinions of the service they received. This showed 100% of people were happy with all areas of the service in the survey. The provider told us they felt the questions in the last questionnaire were leading and not impartial. They were looking at preparing a new form which people could understand better.

The provider had identified a member of staff who had been trained to become a dignity champion. They met with this person to discuss ways in which changes could be made to improve the service for people. An audit had been carried out and an outcome identified was to increase staff awareness of treating people with dignity and respect. A training event was arranged for staff at the next staff meeting. Staff told us the training had been useful and made them think about how they supported people with respect and dignity.