Jeesal Residential Care Services Limited

Creswick House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 5 May and by one inspector on 10 May. The inspection was unannounced.

Creswick House provides accommodation, care and support for up to 14 people living with a learning disability and or mental health needs. At the time of our inspection there were eight people living in the home. The home was divided into two different units. The upstairs of the home was for people with more complex needs who required one to one support.

The registered manager had been in post since 2003. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Staff had an in-depth knowledge of people's care needs and were able to describe how they would protect people from harm. Staff were aware of what would constitute a safeguarding issue and how to raise this. Where risks had been identified with regards to a persons health, these were safely managed. The storage and administration of medicines was safe and there were robust checks in place to ensure that staff were competent in the administration of medicines.

Staff were recruited in to their roles after satisfactory employment checks had been carried out to ensure that only staff suitable to work in the home were employed. there were enough staff employed at the home to meet the needs of the people living at the home. Staff completed a comprehensive induction process and received subsequent training updates relevant to their role. Staff were well supported.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find the manager and staff were knowledgeable about when a request for a DoLS should be submitted but mental capacity assessments were not in place before best interests decisions were made for people.

People's nutritional needs were being met and appropriate advice and support had been sought from professionals such as the GP, speech and language therapist and occupational therapists to inform the care plans of people. The care that was provided was person-centred and care plans reflected this. People were encouraged to be as independent as possible and regular one to one staff support was in place to support this.

A complaints procedure was in place and people who lived in the home had access to a copy of the complaints procedure. This was written in an easy read format.

Staff felt well supported by the management team and were able to speak openly about their suggestions for service improvements. There were regular audits carried out to ensure that the service being provided

was safe and effective. The registered manager had reported notifiable events to the CQC as required.

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 the knowledge and training to keep people safe from harm.

There were systems in place to manage the risks to people's health which had been identified.

Medicines were administered safely.

A sufficient amount of staff were on duty every shift and they had undergone satisfactory recruitment checks.

Is the service effective?

Good

The service was effective.

Staff completed mandatory training and an induction specific to their role and staff felt supported in their role.

Staff had a good understanding of people's care needs and how to support people.

Dietary requirements were catered for when needed. People received input, advice and support from relevant health professionals as necessary.

Is the service caring?

Good

The service was caring.

People were treated in a caring way and their privacy, dignity and individuality was respected.

People were involved in planning their care as much as possible.

People were supported to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People's care was person-centred and it reflected their individual needs and preferences. The care records were clear and gave a detailed description of people's support needs and preferences.

Activities were promoted and people were supported to access activities of their choice.

There was an appropriate complaints procedure in place and complaints were effectively responded to.

Is the service well-led?

Good

The service was well led.

Person- centred care was promoted by management and staff felt supported and that they could raise concerns or suggestions with the management team.

There were systems in place to ensure that the service being provided was regularly monitored.

Creswick House

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 5 and 10 May 2016 and was undertaken by two inspectors.

Before our inspection we looked at information we held about the service, including previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law.

During the inspection we met and spoke with four people living in the home, the manager, the deputy manager and three members of support staff.

We looked at the care records of four people and the medication records for two people who lived in the home.

We also looked at a selection of records that related to the management of the service.

Good

Is the service safe?

Our findings

Our observations and discussions that we had with people demonstrated that the service was safe. We saw that where risks to people's health had been identified, that these were managed safely and effectively. For example, one person used protective headwear because they were at high risk of head injury because of health conditions they were living with. There was a risk assessment in place for this. We also observed a member of staff painting someone's nails. When the staff member was called out of the room, they were mindful to take the nail polish with them.

Staff were knowledgeable about the care needs of people including potential triggers in the deterioration of someone's wellbeing. Staff were aware of people's care plans and how to manage situations where someone could put themselves or others at risk as sometimes people could exhibit behaviour that challenged. We observed staff calmly encouraging someone who was becoming slightly distressed to sit with with them and look at a book.

Where risks to people living in the home had been identified, there were up to date risk assessments in place which outlined what the risks were and how they were to be managed. The risk assessments were reviewed monthly and were all up to date. Some people required one to one support to minimise any risks and there were clear and up to date notes documenting what had happened during the one to one time. In addition to this a record was kept of the observations carried out on people during the night time to ensure their safety. One member of staff we spoke to said that they found the risk assessments to be clear and helpful. They told us about a person they support with their food as they have difficulty swallowing their food. They said that there was clear guidance in the person's care record around meeting this need.

We looked at staff rotas and saw there there were sufficient numbers of staff on duty during the day. This ensured that people living in the home were able to be assisted with activities outside of the home. We saw that there were also sufficient numbers of staff on at night. Staff members we spoke with said that there were enough staff in the home. There were people who required one to one staff support and the manager used a dependency tool to ensure that there were adequate numbers of staff to cover all aspects of people's care.

We found that robust procedures were in place for the recruitment of staff to ensure that only staff suitable for the role were recruited. We reviewed the recruitment files of three staff members and found that at least two references had been sought, one of them being from the last employer and that they had received a satisfactory criminal records check.

People's personal appointments were reviewed in advance when planning the staffing rota to ensure that there were adequate numbers of staff on duty to facilitate this and any additional requests from people living in the home.

Any accidents or incidents involving people from the previous day were also looked at daily. These were documented in the accidents and incidents book and copies were forwarded to the company's compliance

officer. This allowed for the compliance officer to review the accidents and incidents for patterns or trends and make the necessary changes. We looked at equipment and utility safety and servicing certificates and these were all in date. This helped to ensure that the home was a safe place to live and work in.

We looked at two medicine records for people and found that they were being filled in correctly as there were no gaps in the records. No one living in the home was able to self administer their medicines so staff looked after the storage and administration of people's medicines. People had their medicines stored in their room in a locked cabinet. We observed medicines being given and saw that staff signed for the medicines after they had seen it being taken. Medication was checked and audited weekly.

All staff had an annual medication competence assessment. Staff were observed by one of the management team when they were administering medicines. Staff were also expected to know what people's medicines were for and understand what the potential side effects were. If staff were not competent in some areas, for example not being able to explain the side effects of a medicine, action was taken to ensure this was remedied promptly.

Good

Is the service effective?

Our findings

The provider had a comprehensive training programme. When new staff started at the home, they shadowed staff at one of the larger locations within the provider's organisation. New staff then shadowed experienced staff for for two weeks at Creswick House. The manager told us that they and other senior staff would observe new staff and note their ability to interact with people who live in the home. In addition to the observations, all staff employed by the provider were required to complete the provider's care certificate within their first three months of employment. The care certificate is intended to deliver standardised training so that staff develop the necesssary skills and knowledge to support people in a safe and caring way.

We looked at the different training that staff received. All staff had to complete training in equality and diversity, safeguarding, the mental capacity act and signalong. Signalong is a sign-supporting system based on British Sign Language, designed for people with communication difficulties. We saw that staff had regular updates on their training and that the manager had a record of when staff need an update on their training.

One member of staff we spoke with had not been working for the provider very long. They said that within the first two weeks of their employment they had received training in first aid, mental health and food hygiene. They told us that the training was in depth and that other staff were supportive.

Staff had regular supervision with one of the management team. One member of staff we spoke to said that they had supervision with the deputy manager. The member of staff told us they discussed their training and any areas for improvement and staff were asked for their observations and suggestions for improvement within the service. Staff were also asked for their input towards the care of people living in the home.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager told us that everyone living in the home was currently subject to DoLS. We saw that individual DoLS applications had been submitted for everyone living in the home. We noted that there were no mental capacity assessments in place. We discussed this with the manager who informed us that they were waiting for the mental capacity assessments to be completed by the funding authorites for the people living in the home. The manager seemed to lack the understanding that people's mental capacity must be assessed before someone can be deprived of their liberty. The impact of this was minimal as the manager had

assessed the need to deprive people of their liberty as a best interests decision. The manager informed us that they are going to arrange mental capacity assessments for people.

The manager documented best interests decisions that staff had made in terms of people's care and safety and detailed why that decision had been made. The manager informed us that they would contact an Independent Mental Capacity Assessor if someone lacked the ability to make their own significant decisions regarding their care or treatment.

People were supported with individual dietary requirements or preferences. Choices of food were discussed during meetings that were held for the people who live in the home and pictures were used to help people to show their preferred food. In terms of dietary requirements we saw that people who had difficulties with swallowing had an assessment by the Speech and Language Team (SALT). We saw from the care records that the guidance provided by SALT informed detailed care plans and risk assessments around nutritional needs. We also saw that fluid charts were completed, but we noted that drinks were not always readily available. People did not have access to the kitchen and there were no drinks kept in a place that was could be accessed by people. We observed one person being given their medication with a drink, once they had taken their medication, the drink was taken away without asking the person if they would like some more.

We observed lunch in the home. We noticed that someone had a plate guard and that someone else had a spoon instead of a fork so they could maintain independence around mealtimes. Staff sat with people and assisted some people with eating their food. It was noted that some food was cut up and when someone was on a pureed diet, we saw that the food had been pureed.

People received input, advice and support from relevant health professionals such as SALT, GP and occupational therapy. For example, we noted that one person was beginning to develop a pressure sore. We saw from the care records that the staff identified this in a timely manner and they had sought advice from other professionals. Staff told us that they had consulted an occupational therapist and a pressure relieving chair had been ordered. We saw in the notes taken by staff in a SALT assessment that pictures and objects of reference were used to help people understand what the assessment had been for.

Good

Is the service caring?

Our findings

People living in the home were unable to tell us in detail whether they felt that they were involved in decisions about their care. For that reason we listened and observed how staff interacted with people during our inspection. We saw that staff interacted with people in a warm and friendly manner and people appeared to be comfortable in the company of staff. We saw from our observations that staff were caring and we saw a member of staff calmly encouraging people to eat their lunch. In another observation, we saw a member of staff ask someone if they were enjoying the horse racing on the television. The member of staff then told people in the lounge that they had remembered that another person liked the horse racing who was in their bedroom. They went to see if this person wanted to watch the horse racing on their television.

We observed staff to be cheerful and good natured. One member of staff we spoke to said, "In order to build a rapport with people, you've got to know about people." One person we spoke to said jokingly, "[Staff member] makes me behave!" This demonstrated that people living in the home felt as though they could be jovial with staff. Staff gently encouraged people where necessary to be respectful to others. For example, we saw a member of staff prompting a person living in the home to say please and thank you.

Activities in the home were provided by the staff and we saw that a member of staff was painting the nails of some people during our inspection. We saw the member of staff asking people if they would like their nails done and offering people a choice of colour. We saw the staff member ask one person if they would like a pillow behind their back to make them more comfortable.

Through discussions with staff and the information in the care records, we saw that people's privacy, dignity, individuality and independence was respected. For example, we saw in one care record that a person had stated that they would prefer to have their personal needs tended to by a member of staff of the same sex. We spoke to the manager and they said that they ensured that male and female staff were on shift to meet people's preferences. We saw a mix of male and female staff across shifts when we looked at the staff rota. We saw that the care records were clear and detailed. One person's care record we looked at stated that they liked to go shopping for their food but needed staff to accompany them during the shopping trip. A number of people living in the home were given one to one support to enable them to be as independent as possible in the least restrictive way.

People were involved as much as possible in the planning of their own care and making their own decisions. We saw that the care records showed a detailed history of the person and their preferences. Visual aids such as pictures and objects of reference were used to help people communicate their choices and preferences. We also saw that people were able to state how they preferred their personal care to be given and one of the preferences was that they prefer to be around female staff.

Good

Is the service responsive?

Our findings

We found from our observations and discussions with staff that the care and support provided to people was person-centred and people were therefore treated as individuals. Some people living in the home were not always able to communicate their preferences clearly. Every care record that we looked at had a section regarding communication. This gave information on how the person communicated with others and how they prefer others to communicate with them. In one care record we looked at we noted that a person had a communication dictionary which helped staff to communicate with them. One member of staff said that the care records were very helpful as they clearly set out what people's care needs were and what was required in order to meet those needs.

Staff were knowledgeable about the care needs of people including potential triggers in the deterioration of someone's wellbeing. Staff were aware of people's care plans and how to manage such situations as sometimes people could exhibit behaviour that challenged. We observed staff calmly encouraging someone who was becoming slightly distressed to sit with with them and look at a book.

We saw that people were supported to follow their interests. People living in the home were supported with visits in to the local town centre as well as with outings further away and of a longer duration, such as holidays. We saw that one person liked football. The staff at the home had arranged regular days out to the football ground with an outside agency who delivered activities at the ground such as coffee mornings. There were people living in the home who were supported to attend adult education classes and the home ensured that there were enough staff on duty to facilitate activities both inside and outside of the home.

There were weekly meetings for the people who lived in the home. They discussed their preferences for food and what activies they would like to do. This was also an opportunity for staff to let people know if there were going to be any visitors to the home and what the purpose of their visit was. The minutes of the meeting were produced in a clear format and used appropriate languge as well as pictures to depict what was discussed.

At times some of the people living in the home could exhibit behaviour that challenges. There were clear support plans in place around what people's specific behavioural triggers were and how staff could help to support people when they became distressed. We saw from the records that there was an emphasis on managing this in a positive way by promoting decision making and independence. A member of staff we spoke with said that they had received a lot of training around managing behaviour that challenges.

Risk support plans were reviewed every six months and we saw from the care records that we looked at that the six monthly reviews were implemented. In addition to this staff wrote monthly care summaries for people. This was a detailed account of how people had been over the past month and documents what contact they have had with other health professionals. This allowed staff to review people's care package and make changes to meet people's changing needs. For example, if someone started to have difficulty with swallowing, then extra support could be given at meal times and a referral to SALT made.

People were encouraged to maintain contact with their family and friends and we saw that one person was supported with making phone calls to their family twice a week. The manager said that they welcomed relatives and friends to the home.

We saw that there was a complaints procedure in place and the manager spoke to us about how they would deal with a complaint. There are easy-read complaints procedures which explain in a pictorial way how to make a complaint.

Good

Is the service well-led?

Our findings

Staff we spoke with said that they enjoyed working in the home. One member of staff said that the team was supportive and another member of staff we spoke to said that, "The manager always listens and does not take anything personally." Staff felt that they were able to express their views, even if they rasied concerns and made suggestions in team meetings. Staff meetings were held every three to four weeks and we looked at the minutes for three of the staff meetings. We noted that the meetings spoke about a range of issues such as updates on people's care and any new guidance on best practice. Staff told us that they were only allowed to miss a few staff meetings a year. The manager told us that the staff meetings were a good opportunity to discuss any incidents that may have occurred. The staff team were encouraged to talk about how the incident could have been dealt with differently and what they could learn from the incident.

As well as the staff meetings, there were weekly meetings for the people who lived in the home. These meetings discussed which staff were on duty that week and the reasons for any absences, meal choices and activities.

At the time of our inspection there was a registered manager in post. This person had been the registered manager since 2010.The registered manager was aware of what notifiable incidents needed to be reported to CQC and they were reporting these events as required. A notification is information about important events the provider must inform us about by law.

The provider's senior management team carried out regular in-depth audits on a three monthly basis and the audit focused on a specific area such as medication, care plans, the internal and external environment of the home and care records. We saw that accidents and incidents were recorded and reported correctly. Copies of this paperwork was sent to the provider's compliance officer so accidents and incidents could be audited to help identify any trends and to put in preventative measures.

Internally, we saw that there were systems in place to ensure that the service provided was regularly monitored. We saw that care records, care plans, and risk assessments were reviewed and updated regularly.

Environmental risks in the home were well managed and there was a daily check of the interior and exterior of the home. Daily fire checks were also completed and were up to date. The temperatures of the fridge and freezer in the kitchen were recorded daily and checks were carried out on the cleanliness of the kitchen. More in depth audits around health and safety were completed at weekly and six monthly intervals.

The manager told us that they liked to be present in the home. They told us that they liked to observe staff themselves. "I observe them and if I see anything I pick it up and deal with it immediately." The manager added that they have "…vigilant seniors" who would report any poor practice.