

Jeesal Residential Care Services Limited

Shulas

Inspection report

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22 September 2021

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Shulas is a care home that provides accommodation and personal care to people with a learning disability and/or autistic people. The service can support up to six people. At the time of our inspection there were six people living at the service. The service was divided into two flats, with three people living in each.

People's experience of using this service and what we found

The provider had failed to ensure the quality of care was monitored at Shulas. There was no effective system of governance in place and quality assurance systems were not embedded within the service. Some audits had been completed by the registered manager however, these were not always effective at identifying areas for improvement.

Incidents were reviewed and signed off by the registered manager, but no analysis was completed with a view to identify patterns and trends. There was limited evidence that lessons learnt were considered and shared with the team to prevent any reoccurrence.

Risk assessments were in place and these contained sufficient detail about how staff should support people, in line with their needs. However, there were inconsistencies between paper care records and the electronic care planning system. In addition, behavioural support plans varied in detail and contained insufficient guidance about how to support people effectively in different situations.

There were several environmental concerns at Shulas, which had been identified by the provider and were in the process of being addressed. However, we saw evidence that these issues had been ongoing for a significant period of time. The registered manager explained how these had been raised with the provider on several occasions but had not been addressed in a timely manner. This meant people had been living in unacceptable living conditions, with potential risks to their health and safety.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of the key questions of safe and well-led, the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Shulas is a domestic property, with the building fitting into the local residential area and there was nothing outside to show it was a care home. People were provided with care that did not consistently promote their dignity, privacy and human rights. The provider had not fully considered how to maximise people's choice, control and independence. Work was required to identify and support people to achieve their goals and

aspirations.

We have recommended the service reviews the 'Right support, right care, right culture' guidance and considers the ways in which it can further promote person-centred care, which promotes choice, inclusion, control and independence.

Staff had received safeguarding training, were able to identify different types of potential abuse and knew how to report any concerns both internally and externally. Staffing levels were sufficient, and medicines were managed appropriately.

People, relatives and professionals provided us with positive feedback about the registered manager. Staff told us they felt well supported.

We were somewhat assured the service was managing infection prevention and control risks, in relation to COVID-19 appropriately and in line with guidance.

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

Rating at last inspection

The last rating for this service was good (published 05 September 2017).

Why we inspected

We received concerns in relation to the provider. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Shulas on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified two breaches in relation to the environment and premises and good governance at this

inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

Shulas

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was undertaken by one inspector.

Service and service type

Shulas is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 26 August 2021 and ended on 22 September 2021 when we gave feedback to the provider. We visited the service on 26 August 2021.

What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection

We spoke with four people who used the service. We observed people's interactions with staff and the support they were offered. We spoke with the registered manager and deputy manager. We reviewed one person's care records and checked medication for one person. We also reviewed a variety of records relating to the management of the service.

After the inspection

Following our visit to the service, we spoke with one relative, one advocate and two professionals about their experience of the care provided. We also spoke with five staff members. We accessed the provider's electronic care planning system. We reviewed incident and accident data, recruitment records, training data and quality assurance records and continued to seek clarification from the provider to validate evidence found.

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- During the inspection we identified concerns in the physical environment at Shulas. The registered manager was aware of these issues and was taking steps to address these. However, it was evident that people had been living in an unsatisfactory environment for a number of years. One member of staff told us, "Since the CQC inspections at the other Jeasal homes, a lot of works have been authorised here." The registered manager informed us that despite repeatedly raising concerns, it was only in November 2020 that the provider released funds for investigatory and remedial works to be completed.
- We saw evidence that work had been completed to rectify issues found during a recent fire safety inspection and plans were in place for some re-decoration. However, there were ongoing concerns about the structural integrity of the building, which were still being addressed at the time of inspection.
- There was a large area of damp in the upstairs kitchen and damage to the kitchen worktop. Both of these issues were potential infection control risks. We saw evidence that quotes had been obtained and this work was due to start in a month.

The provider had failed to ensure people lived in a safe and well maintained environment. This was a breach of Regulation 15 (Premises and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Risk assessments were in place and contained sufficient detail about how staff should support people, in line with their needs. However, assessments were not consistent between paper care records and the electronic care planning system. However, staff knew people well and had worked with them for a number of years. This helped to mitigate some of the risk associated with this.
- Some people required support to manage their anxieties. However, behavioural support plans varied in detail and contained insufficient guidance for staff about how to support people effectively in different situations. Staff had received positive behavioural support training however; this approach had not been fully embedded at the service.
- One person had a history of becoming destructive to their environment, when feeling unsettled. This was not reflected in their risk assessment or behavioural support plan. The registered manager was awaiting professional support from the local learning disability team, at the time of inspection, however no interim plans had been put in place to guide staff as to how they should support this person.

Learning lessons when things go wrong

- Incidents were recorded on the electronic care management system. These were reviewed and signed off

by the registered manager. However, they were not analysed for patterns or trends and there was limited evidence that lessons learnt were considered, to prevent any reoccurrence.

- Staff told us that when incidents occurred, the staff involved would meet with the manager to discuss what had happened. However, these sessions were not documented and there was no evidence of any learning being shared with the wider staff team.
- Following the inspection, the registered manager implemented a new log at the service to evidence outcomes, actions, themes and trends.

Staffing and recruitment

- Staffing levels were sufficient to meet the needs of people using the service.
- Staff told us that there were sometimes challenges in ensuring everyone received individual attention, within the hours commissioned, and explained that activities often had to be pre-planned. One staff member told us, "It is difficult to facilitate one to one time with people, certainly on a spontaneous basis. It has to be a planned activity."
- Staff recruitment records were managed centrally. Prior to commencing employment staff were subject to a criminal record check and references were obtained from previous employers. However, we found that staff's full employment history was not always obtained.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Staff had received safeguarding training, were able to identify different types of potential abuse and knew how to report any concerns both internally and externally.
- A log was in place for recording safeguarding concerns. There had been no recent safeguarding concerns within the service.
- One relative told us, "[Relative]'s safety and development has been a priority at Shulas." An advocate told us, "The service definitely meets [name]'s care needs, and they probably go above and beyond to make sure they are safe, comfortable and happy."

Preventing and controlling infection

- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Staff confirmed that they had been working across different services throughout the pandemic. This meant there was a risk of staff spreading COVID-19 across the provider's care homes.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance

Using medicines safely

- People's medicines were managed safely and administered by staff who were fully trained, and whose competency had been assessed. Medicine records included guidance for administration and a description of each medicine in use.
- Daily medicines checks were completed to ensure any discrepancies could be identified and rectified quickly. The stock of the medicines were also maintained and recorded accurately.

- Each person living at Shulas had received a medicines review within the past 12 months.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care; Positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- The provider had failed to ensure the quality of care was monitored at Shulas. There was no effective system of governance in place. Recent CQC inspections of the provider's other services identified the same concerns. Despite this, limited steps had been taken to implement changes. This demonstrated an insufficient commitment to continuous learning and improving care and exposed people to the risk of continuing to receive poor standards of care.
- Concerns regarding the physical environment at Shulas had not been identified and addressed in a timely manner. This meant people had lived in substandard accommodation for a significant period of time that posed risks to their health and safety.
- The provider had failed to operate a robust quality assurance system. An external consultant had completed a quality assurance audit, but this had failed to identify issues found at this inspection. The resulting action plan had been signed off as completed. However, there was no evidence that these findings had fed into an ongoing service improvement plan. We found that not all actions had been completed.
- The registered manager and deputy manager completed monthly medicines and health and safety audits; however, it was not clear what records or evidence had been reviewed. As such, it was difficult to determine how judgements had been reached. We asked for audits of care plans and risk assessments but were informed that these checks were not completed.
- The registered manager did not analyse accidents and incidents, which meant they were unable to identify emerging patterns or trends, with a view to identify potential areas for improvement or to prevent reoccurrence.
- The registered manager was registered to manage two services within the provider group. However, at the time of inspection, they had also been required to oversee the closure of a third location, the transition of each person living there and to have management oversight at a fourth location. They confirmed this had been a challenge and had impacted on their oversight at Shulas. The provider failed to identify this and take action to support the registered manager or staff team during this time.
- The principles of right care, right support and right culture were not embedded at the service and the provider was not following best practice in this area. People were not engaged in service delivery in a meaningful way, as partners in their care. We saw that weekly meetings took place, where people were able to discuss what they had enjoyed doing that week and what they would like to eat during the following

week. However, beyond this, we did not see any evidence that people were asked for their feedback about the service they were receiving. We saw no evidence that people were supported to identify goals or be supported to achieve their aspirations.

- The registered manager lacked knowledge of key practices and guidance. For example, we saw an application had been for a deprivation of liberty safeguard (DoLS) for a person who was able to go out independently and did not require continuous supervision. This suggested a lack of understanding regarding the process and the requirements of the Mental Capacity Act (MCA). This had not been identified by the governance systems in place.
- The provider did not promote the right culture. For example, on their website they referred to "available beds" within each location, rather than respecting them as people's homes. Furthermore, the webpage for Shulas contained a video about the service. We saw no evidence that people had been involved or consulted about the use of their home in this way.
- The registered manager did not consistently role model the values associated with right care, right support and right culture. For example, when telling us who was living at the service, they referred to people by their local authority funding rather than their names. This meant the values within the home did not support the development of best practice for supporting people with a learning disability.

The governance system at the home was not effective or robust enough to identify improvements needed within the home. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We saw evidence that feedback surveys had been sent to relatives and professionals during the past 12 months. Feedback received was generally positive and no areas for improvement were identified.
- Staff spoke about people in a positive way. Staff were able to tell us about the individual likes and dislikes of the people they support.
- Staff felt supported by the registered manager. One staff member said, "I do feel supported. If I come to [registered manager] or [deputy manager] with something it is normally sorted within the week. [Registered manager] will make time for you."
- Staff had access to regular supervision and team meetings. They told us they felt able to feedback and make suggestions about how the service operated. One staff member told us, "I make suggestions and give feedback every day. I do feel supported."
- People were observed to be happy in the company of staff on the day of inspection. Relatives gave us positive feedback. One relative said, "I feel very comfortable and would not hesitate to raise any concerns about the quality of [name]'s care. The staff are very approachable and helpful."

Working in partnership with others

- The registered manager worked with other professionals to meet people's needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure people lived in a safe and well maintained environment. Regulation 15 (a) (c)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The governance system at the home was not effective or robust enough to identify improvements needed within the home. Regulation 17 (2) (a) (b) (c) (d) (e) (f)

The enforcement action we took:

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