The White Horse Care Trust

Shalom

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

Shalom is registered to provide accommodation, including personal care, for up to 4 people with a learning disability and associated health needs. The service is one of many, run by the White Horse Care Trust, within Wiltshire and Swindon. At the time of our inspection 4 people were living in the home. The property is a detached house situated in the village of Baydon, Wiltshire. People had their own bedrooms with shared use of a communal lounge, dining room, kitchen area and gardens.

The inspection took place on 01 February 2016. This was an unannounced inspection. During our last inspection in June 2014 we found the provider had satisfied the legal requirements in all of the areas that we looked at.

A registered manager was employed by the service. 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.

People were supported by kind, caring staff who knew them well and understood their care and support needs. Relatives spoke positively about the care and support their family member received. They felt people had developed caring relationships with staff. People were supported to take part in social activities both within the home and community.

People were supported to maintain relationships with people that mattered to them. Relatives were kept informed of their loved ones health and well-being and any changes in their needs.

People were kept safe by staff who recognised signs of potential harm or abuse and knew what to do when safeguarding concerns were raised. Staff felt confident concerns raised would be listened to and acted upon by the registered manager and deputy manager.

People were supported to have sufficient to eat and drink and maintain a balanced diet that promoted healthy eating. People had access to dietary and nutritional specialists to help meet their assessed needs.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place for the safe management of medicines. People received their medicines as prescribed by staff that were trained to do so. Referrals were made to relevant health professionals when needed and each person had a health action plan in place.

Staff told us they felt supported by both management and colleagues. Staff received training as required by the provider and regular supervision to enable them to meet people's needs.

There were enough staff deployed to fully meet people's health and social care needs. The registered

manager and provider had systems in place to ensure safe recruitment practices were followed.

Staff and the registered manager had an understanding of the Mental Capacity Act (2005).
Staff were knowledgeable about the rights of people to make their own choices and decisions. This was reflected in the way staff supported and encouraged people to make decisions when delivering care and support.

Staff understood their roles and responsibilities in relation to infection control and hygiene. During our inspection we saw the home was clean, tidy and free from odours.

The provider and registered manager had systems in place to monitor the quality of service. Relatives of people using the service were encouraged to share their views on the care and support their family member received.

There were systems in place to respond to any emergencies. Staff had access to a 24 hour on call system to enable them to seek advice in an emergency. People had personal emergency evacuation plans in place in the event of an emergency such as fire.

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

This service was safe.

Staff had received training to recognise abuse and knew what action to take should they suspect abuse had taken place.

Medicines were managed appropriately by trained staff.

Risks were identified and assessed and plans put in place to protect people whilst promoting their independence.

Safe recruitment practices were in place and there were enough staff deployed to meet people's.

Is the service effective?

Good

This service was effective.

People were supported by staff who had the skills and experience needed to meet their needs.

Staff understood the requirements of the Mental Capacity Act 2005. Where people had been deprived of their liberty, authorisation from the local authority had been requested.

People were supported to have sufficient to eat and drink.

Is the service caring?

Good

This service was caring.

People were looked after by kind and caring staff who knew them well.

Relatives spoke positively about the care and support their loved one received.

People were comfortable in the presence of staff and did not hesitate to seek assistance when required.

Is the service responsive?

Good

This service was responsive.

Care plans were centred on the person and provided information to staff about people's care needs and how best to support them.

There were processes in place to deal with complaints. Relatives knew how to make complaints and said they felt comfortable with raising concerns.

Is the service well-led?

Good

This service was well-led.

There was a registered manager in post who was responsible for the day to day running of the service.

The provider and registered manager had quality assurance systems in place.

The service had a clear set of values that included treating people with dignity and respecting and supporting people to be as independent as possible.

Shalom

Detailed findings

Background to this inspection

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

This inspection took place on 01 February 2016 and was unannounced. One inspector carried out this inspection. During our last inspection in June 2014 we found the provider satisfied the legal requirements in the areas that we looked at.

Before the inspection we checked the information we held about the service and the service provider. This included statutory notifications sent to us about incidents and events that had occurred at the service. A notification is information about important events relating to the care they provide which the service is required to send to us by law. We also looked at previous inspection reports.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with the relatives of two of the people living at Shalom about their views on the quality of the care and support being provided. Due to the nature of people's learning disability and communication difficulties we were not able to ask direct questions. We observed staff supporting and interacting with people and spoke with the registered manager, deputy manager and three members of staff.

We looked at records relating to people's care and support and the management of the service. We reviewed a range of documents which included two care and support plans, staff training records, staff duty rotas, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Good

Is the service safe?

Our findings

People were protected against the risk of potential harm and abuse. Staff were trained in safeguarding vulnerable adults and were aware of the different types of abuse people may experience such as verbal, physical or financial. Staff knew who they should report any concerns to and what actions they should take should they suspect abuse had taken place. For example staff said in the first instance they would ensure the person was safe and possibly remove them from the situation. They would then report their concerns to the registered manager, deputy or person in charge of the shift. Staff were confident that any concerns raised would be listened to and acted upon. Staff had access to safeguarding information via posters and policy documents. Relatives we spoke with felt their loved ones were safe and well cared for. Comments included "I am very happy with the way they look after X and keep her safe" and "They are very supportive and are focused on taking care of him".

Risks to people had been identified, assessed and managed appropriately. There were risks assessments within people's care records for personal care, nutritional needs and daily routines. Where people were at risk of falling appropriate equipment, such as sensor mats, had been purchased. This supported people to maintain their independence and spend time in their bedrooms but would alert staff should the person become mobile. Staff were then able to check the person was alright and provide any assistance required.

Accidents and incidents were recorded and analysed to help the staff team identify and understand any patterns or trends. This enabled them to think about anything they could be doing differently and if referrals to other health professionals for support and guidance were required. For example, one person had experienced regular falls. Falls were recorded and as a result of this staff told us the GP had been contacted for advice. The outcome of this was a sensor mat had been placed in the person's bedroom. As they were prone to falling when getting out of bed this alerted staff they had got up and support could be offered.

People's medicines were managed so they received them safely. Medicines were ordered, stored administered and disposed of in line with the provider's medicines management policy. Staff had been trained to administer medicines safely and training records confirmed this. Staff told us they were observed administering medicines to people by management before being signed off as competent. Medication administration record (MAR) sheets had been completed and signed by staff appropriately. We observed a member of staff supporting a person to take their lunchtime medicines. Staff checked they had the correct medicine and dosage against the information on the person's MAR sheet. They then took the medicine to the person who was in their bedroom. The staff knocked before entering and explained to the person it was time to take their medicine. The person was supported to take their medicine in their preferred way and at a pace appropriate for them.

Staffing levels were assessed and monitored by the registered manager to ensure there were sufficient staff available to meet people's needs at all times. There were enough staff on duty to ensure people's needs were met and they were supported to take part in planned activities either within the home or the community. The service had access to an on-call service to ensure management support could be accessed at any time. People were protected from the risk of being cared for by unsuitable staff. There were safe

recruitment and selection processes in place to protect people receiving a service. We looked at three staff files to ensure the appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work performance. New staff were subject to a Disclosure and Barring Service (DBS) check before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

The provider had systems in place to make sure the premises were safe and to respond to foreseeable emergencies such as fire. There were personal emergency evacuation plans in place for people, which provided advice to staff on their safe evacuation in the event of an emergency.

Good

Is the service effective?

Our findings

People had their needs met by staff with the necessary skills and knowledge. A system was in place to provide staff with core training required by the provider. This ensured they had the correct skills and knowledge to carry out their role. Core training included the safeguarding of vulnerable adults, infection control, moving and handling and fire safety. We looked at the training matrix, which showed training staff had undertaken. Training needs were monitored by management through individual support and development meetings with staff. New members of staff received a thorough induction which included shadowing an experienced member of staff.

Regular meetings were held between staff and their line manager. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had. However, staff told us they could approach the registered manager at any time to discuss any suggestions or raise any issues. Staff received an annual appraisal of their performance. Staff attended team meetings at which information was shared and people's needs were discussed.

Communication was effective. There was a handover meeting between shifts which was also documented. At these meetings information was shared about how people they were supporting had spent their time. Staff passed on any issues or concerns that the staff coming on duty needed to be aware of. All the staff we spoke with were knowledgeable about the people they supported and had an understanding of how people communicated and what their preferences, likes and dislikes were. To support people with communication, one staff member explained they used objects of reference to support the person to know what was going to happen. For example they would use the person's cup to ask if the person wanted a drink or a spoon to indicate it was a meal time. People's emotional and physical needs and how these could be met were discussed during supervision and team meetings. Staff told us and records confirmed that they used the meetings to discuss what was going on in the person's life and if any changes to care and support were required.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Care plans included people's preferences for food and drink. For example in one person's care plan it recommended the person's food be cut up small to minimise the risk of choking. We saw during lunch the person's sandwich was cut up into manageable bite sized squares. It also noted they preferred hot drinks instead of cold drinks. We had previously read in the person's health notes that the doctor had recommended the person have additional salt added to their evening meal. However we could not find this information in their nutritional support plan. Staff were aware and told us they added the salt to the person's evening meal. We spoke with the registered manager who said they would rectify this immediately.

People were supported to maintain good health and had access to the appropriate healthcare services. For example people had access to a doctor, optician and dentist. Appropriate referrals were made to specialised health professionals when required such as the Speech and Language Therapy (SALT) team. One relative

told us when their family member first moved to Shalom staff were "Quick" to make the necessary referrals to health professionals such as the occupational therapist and wheelchair advisory clinic. This had included registering the person with a local doctor and supporting them to attend an introductory appointment. This was an opportunity for the person to meet the doctor and for them to discuss and review the person's medical requirements.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). 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 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).

Staff demonstrated a good understanding of supporting people to make choices and decisions about their daily living. They explained people were always offered the choice of what they wanted to eat and drink and how they wanted to spend their day. We observed staff for the most part sought permission from people before undertaking any care or support. We discussed with the registered manager that at times staff did not seek permission before wiping people's faces with wet wipes. We also noted whilst people were made aware of what was for the lunch time meal, which was based on their preferences, they were not asked what they would like for lunch and instead the meal was prepared for them. The registered manager explained there were pictorial cards available to support people making food choices and would remind staff about these.

Where people did not have the capacity to make decisions for themselves, mental capacity assessments had been undertaken. Meetings had been held to discuss decisions made in the person's best interest. Relatives confirmed they were always consulted in matters relating to decision making about their family member. The registered manager told us where required applications for DoLS authorisations had been made. Applications had been submitted by the provider to the local authority and they were awaiting a response.

Good

Is the service caring?

Our findings

Staff had a caring, compassionate and at times fun approach to supporting people. They knew people well and demonstrated a good understanding of the preferences and personalities of the people they supported. Staff had developed caring relationships with people and we saw people were totally at ease with staff and their surroundings. We observed staff communicated with people in a warm, friendly and respectful manner which took into account their needs and understanding. For example, one person had not been well during the night and had required additional medicines. Staff were aware of this and ensured the person was made comfortable and kept warm throughout our visit.

Relatives spoke positively about the care and support their family member received. Comments included "The staff at Shalom are amazing. They are good at noticing X's moods and working out what is upsetting him", "Everyone is great. They talk with him and not at him" and "All staff are approachable and know X well".

Guidance in people's care plans promoted people's privacy and dignity. People's care records guided staff in protecting people's privacy and dignity during aspects of their day such as supporting people with intimate care. Staff told us how they promoted people's privacy and dignity by ensuring they knocked before entering a person's room. They ensured any personal care was carried out behind closed doors. We observed safe discreetly informing people that it was time to have their personal care needs met. People's care was not rushed enabling staff to spend quality time with them. Staff frequently sat with people, chatting about the day and checking they were alright. In the afternoon people took part in arts and crafts with staff.

Staff communicated with people effectively and respectfully. For example, if an individual was sitting down staff would crouch down or sit next to the person whilst engaging in a conversation. Staff did not talk over people and everyone was included in conversations. When answering our questions staff made the person aware of the discussion we were having and included people in the information they were sharing.

Due to the nature of people's learning disability and communication difficulties they were not able to answer direct questions about their care and support. Relatives were supported to express their views and were actively involved in making decisions about their family members care and support. Everyone had their own keyworker, which is a named member of staff who, along with the person, family and other staff, was responsible for co-ordinating all aspects of the person's care needs.

Staff took care to maintain and promote people's well-being and happiness. For instance, one person had not eaten breakfast. Staff respected this choice but intermittently throughout the morning checked if this person was ready for breakfast. Staff ensured they did not make the person anxious by insisting the person sat at the table to eat their meal. Staff explained they recorded this person's food intake to monitor if they were eating sufficiently. Records we looked at confirmed this. However when the person had refused food, staff were only recording 'refused' and not if an alternative had been offered. We discussed this with the manager who said they would address this with staff. A relative told us that moving to the home had made a

"Massive difference" to their family member's well-being. They said "He is so much more alert and is getting out of bed more. His episodes of self-harming have reduced. He is making more noises which is a sign he is happy. Him living there is a dream for us. They are looking after him so well".

People were supported to maintain relationships with people that mattered to them. Relatives told us they were welcome at the home at any time and were able to visit on a regular basis. They confirmed they were included and involved in the planning of their family member's care and support. Comments included "We are always included in her care plan and are happy to make suggestions" and "We met with the manager to discuss his care needs. We discussed his needs and what he liked to do".

Each person had their own room which had been personalised to reflect preferences. One person's room had been decorated to reflect their love of buses with a large bus painted on one wall. A relative told us their family member enjoyed having different coloured lights and music playing in their room which they said the staff made sure was switched on. During our inspection we saw the person liked spending time in their room and staff had put the lights on for them.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Comments from relatives included "Whilst continuing to get to know him, they have picked up his care needs very quickly" and "They know her very well and can pre-empt her needs".

People's needs had been planned for. Each person's needs had been assessed before they came to live at Shalom. A relative confirmed they and their family member had been able to visit the service before the decision was made for the person to move in. They said they had been involved in the assessment process and then planning for their family member's care. The initial assessment and previous care plan were used to develop detailed care and support plans to guide staff in how the person wanted and needed to be supported.

People or their relatives were involved in developing their care and support plans. Where people were not able to directly express their views on care and support needed, staff explained this was done through observation. They said they would observe people's body language and behaviours to identify if the person liked or disliked something. Care plans were personalised and detailed daily routines specific to each person. Speaking with staff they were able to explain people's preferences, likes and dislikes. They said one person liked to carry beads with them which we observed them doing throughout our inspection. Another person liked to watch murder mysteries and staff asked the person if this was what they wanted to watch on the television.

Care plans provided comprehensive, detailed information about people including their personal history, individual preferences, interests and aspirations. They were centred on the person to ensure people received the correct care and support they needed. For example, they included details of people's daily routines. This meant staff were able to support people in the way they wanted or needed to be supported to maintain their health and well-being. One person's care plan contained details informing staff of when the person displayed a particular behaviour, what they were trying to communicate and how staff should respond. This ensured the person received a consistent approach with their support from the staff team. Plans also included people's health conditions.

Records contained clear actions for staff to take so people received the help and support they needed. The actions were reviewed on a regular basis. Staff told us they were provided with enough time to read people's care plans and were always informed of any changes to care and support. Staff were able to describe people's emotional and physical needs. They told us about the sort of things people liked to do and care plans reflected what we had been told.

There was a complaints policy in place. Relatives told us they knew how to make a complaint and who to speak with but they had not had cause to raise any. They felt they would be listened to and any actions needed to resolve the situation would be taken. Relatives said they had a good working relationship with the management and staff team. Staff told us people would not be able to verbally say if they were unhappy with something. However, they said they monitored people's well-being and if they felt a person was

unhappy with any elements of their care they would report it to the registered manager. They said they would try and find out what was making the person unhappy.

Good

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a deputy manager. Management and staff described an open and supportive culture within the service and told us they felt able to raise concerns or make suggestions. One member of staff told us "I really enjoy working here, the manager is very supportive". Staff and relatives told us the registered manager was approachable and were available for advice and a chat whenever they needed to. A relative told us "The manager is very approachable. She takes things you say to her seriously and will try to find a solution".

Staff said the registered manager was a positive role model due to her being "Hands on". They said because the registered manager supported people this meant she knew them well and understood their needs. This helped the registered manager with supporting and teaching staff to ensure best practice when providing care for people.

Staff meetings provided the team with an opportunity to discuss people's specific needs and achievements, raise any concerns and put forward any ideas to improve the service for people and staff. One staff member told us about their idea to merge paperwork to save staff time and ensure staff did not forget to complete the information. The registered manager had listened and implemented their idea.

Staff were supported to question practice. The provider had a whistleblowing policy. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. Staff told us they felt if they did raise a concern they would be listened to and they would be taken seriously. They felt the registered manager would take action to resolve their concerns.

The registered manager had made links with the local community. People attended events such as Bonfire night. They had access to the local pub and shops. The registered manager explained that previously when they had attended a fireworks evening they had great difficulty accessing the event with people who were in wheelchairs. The following year the organisers had made arrangements to ensure the event was wheelchair accessible.

The provider had systems in place to monitor the quality of the service. These included audits carried out periodically throughout the year by the registered manager, the deputy manager and staff members who had responsibility for certain areas. The audits covered areas such as infection control, fire safety, the safe management of medicines and health and safety. We saw records of recently completed infection control and health and safety audits. Members of the senior management team visited the home periodically throughout the year. Records on their observations were noted and any actions needed. Where actions had been identified, staff signed to say when they had been completed. There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. Staff members' training was monitored by the registered manager to make sure their knowledge and skills were up to date. There was a record of when staff had received training and when they should receive refresher training.

To keep up to date with best practice the registered manager explained they attended a monthly meeting

with managers from other homes within the trust. This gave them the opportunity to share ideas and discuss working practices. They regularly reviewed processes within the service and sought ideas and feedback from staff. They also received information form external agencies such as newsletters and updates. We discussed with the registered manager, their plans for the service, for the coming year. They explained they would be introducing the new care certificate for new staff members on induction. They were also implementing a new paperwork system, which they hoped would reduce the amount of paperwork staff needed to complete in people's care plans. This would mean staff were not spending so much time on completing and reading paperwork.

Management operated an on call system to enable staff to seek advice in an emergency. This showed leadership advice was present 24 hours a day to manage and address any concerns raised. There were procedures in place to guide staff on what to do in the event of a fire