Jeesal Residential Care Services Limited

Shulas

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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection was undertaken by one inspector on 6 February and was unannounced.

Shulas provides accommodation, care and support for up to six people with a learning disability. At the time of our inspection there were five people living in the home.

The home had a registered manager in post. 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 legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Staff understood how to recognise and report concerns if they suspected people were experiencing abuse. Staff had also received appropriate training in respect of protecting people. People told us that they felt safe living in the home.

People were supported by sufficient numbers of staff, who received regular support and supervision, as well as

Summary of findings

training that was relevant to their roles. Robust recruitment procedures were in place and staff were only employed within the home after all pre-employment checks had been completed satisfactorily.

Medicines were stored, managed and administered safely.

People's care records contained appropriately detailed risk assessments and guidance for staff to follow, which covered relevant aspects of people's daily lives. These helped ensure that people were supported and cared for safely and that risks to their health, welfare and safety were minimised.

Staff interacted with people in a natural, warm and friendly manner and people were comfortable in the presence of all members of staff.

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. We found that the manager and staff were knowledgeable about when a request for a DoLS would be required.

People's individual dietary needs were catered for in line with their care plans and people were able to have sufficient amounts to eat and drink.

All the people living in the home were involved in planning their own care and support. Care records were person centred and provided clear information regarding people's histories, as well as their needs, preferences and choices.

People undertook work, hobbies and leisure activities of their choosing. People also chose when and what they wanted to do and where they wanted to spend their time.

Everyone we spoke with told us that they knew how to make a complaint if they needed to and that they felt they were listened to and any concerns taken seriously.

People living in the home were fully involved in the running of the home, including many aspects relating to the further improvement and the development of the service as a whole.

The home was being effectively managed and regular audits were completed, covering areas such as safeguarding, medication, health and safety, care plans and the overall environment.

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?
The service was safe.

Good

People living in the home said they felt safe. Nobody was restricted in the home and everybody was able to come and go as they pleased.

Staff had a good understanding of the procedures for safeguarding people from harm and who they needed to report any abuse to if it was ever suspected.

Medicines were managed and administered safely.

There were sufficient numbers of staff on duty and prospective staff underwent thorough pre-recruitment checks to ensure they were suitable to work in the home.

Is the service effective?
The service was effective.

Good

Staff were supported by way of relevant training, supervisions and appraisals to deliver care effectively.

People were able to eat and drink sufficient amounts and their individual dietary needs were respected and supported.

Staff understood their responsibilities in respect of the Mental Capacity Act 2005 and, where restrictions were needed in the interests of people's safety, the manager understood and applied the Deprivation of Liberty Safeguards (DoLS) appropriately.

Is the service caring?
The service was caring.

Outstanding

People living in the home told us that the staff knew them really well and cared a lot about them.

Staff interacted with people in a natural, warm and friendly manner and there was constant joviality.

People were fully involved in planning their own care and had regular contact with their friends and family members.

People were constantly supported to enhance and maintain their independence.

Is the service responsive?
The service was responsive.

Good

People living in the home were recognised and treated as individuals and the care and support provided was person centred. People were fully involved in planning their own care and support.

People undertook work, hobbies and leisure activities of their choosing. People also chose when and what they wanted to do and where they wanted to spend their time.

Summary of findings

People told us that they knew how to make a complaint if they needed to and that they felt they were listened to and any concerns taken seriously.

Is the service well-led?

Good

The service was well-led.

People living in the home were fully involved in the running of the home, including many aspects relating to the further improvement and the development of the service as a whole.

The home was being effectively managed and there was visible leadership within the home.

Systems were in place to ensure the quality of the service was maintained and regular audits were carried out, that included the views of people living in the home, relatives, visitors, staff and other healthcare professionals.

Shulas

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 6 February 2015 and was undertaken by one inspector.

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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

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

We looked at care records for four people and the medication records for the three people we met who were living 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

People we spoke with told us they felt safe living in Shulas. One person we spoke with told us they were very happy and felt, "totally safe". They said, "I tell staff if I'm worried, I can talk to all of them. We've got really good staff here, they look after us really well – I like them all".

Another person said, "The staff make sure we stay safe. I don't go out without staff – it's safer that way…" We saw that this person's care records and risk assessments reflected their needs appropriately and provided clear information and guidance regarding the support they needed when going out in the community. Our conversation with this person, together with the information seen in their care records, confirmed to us that they had agreed with the way they were supported and were not being restrained or discriminated against in any way.

Staff spoken with confirmed that they understood what constituted abuse and that they knew the correct reporting procedure. They also told us that they believed that all the staff were confident and would report anything they were concerned about straight away. The training records we looked at showed that staff had completed training sessions in safeguarding, and protecting vulnerable adults. Up to date contact information for people in the safeguarding and adult protection teams was also available for staff and people using the service.

We saw that individual and 'person centred' risk assessments had been completed in respect of all aspects of people's everyday lives. Where new or potential risks were identified, the information and guidance for staff was promptly updated to reflect the relevant changes. For example, assessments explained how people could safely access the local community or undertake activities with or without staff support.

Health and safety audits were carried out by staff each week and reviewed areas such as electrics, heating, flooring, furniture, hygiene standards, mobility equipment and fire safety. We saw that where any issues were identified, these were addressed promptly and appropriate arrangements made to have the issues resolved.

Staff had access to a list of emergency contact numbers that showed who to call in respect of issues with regard to plumbing, electrics, heating, alarms and lighting etc. These measures helped ensure that people were kept safe and able to live in a safe environment.

The staff that supported people living in Shulas were part of a team that also supported the people who lived a few doors away, in another of the provider's homes. The manager was registered to manage both of these homes.

We saw that there were consistently enough staff on duty to support people and safely meet their needs. We also saw that staffing levels were constructively organised between the two houses and adjusted, as needed. It was evident from this that the priority was to ensure that people were able to safely carry out their daily routines, activities, attend medical appointments or have one-to-one staff support as required.

The sample of rotas we looked at, for six consecutive weeks, showed that all shifts had been covered with sufficient numbers of staff. We saw that sickness levels were minimal and, where staff were away from work on planned leave, these shifts were either covered by other members of the regular team or by using staff from other locations, also owned by the provider.

This meant that people using the service were continually supported by a stable team of staff, whom they were familiar with, and that had a good knowledge of each person's individual needs.

Discussions with staff and the staff files we looked at, showed that the home followed safe and appropriate recruitment procedures. All staff were checked for suitability with the DBS (Disclosure and Barring Service), previously known as the Criminal Records Bureau, and appropriate references were obtained before they started working in the home.

From our discussions and some of the records we looked, we saw that people living in the home were actively involved in the recruitment process and could be part of the interview panel when interviewing prospective new staff.

Each person living in Shulas had their medicines stored in a lockable safe, in their own rooms. All the people we met and spoke with told us that they knew what their medicines were for and explained how they took them with staff support. Two people showed us that they also had their own fridges in their rooms, which they could store some

Good

Is the service safe?

things if needed, such as eye drops or medicated creams. We saw that each fridge had a thermometer inside and that temperatures were checked and recorded every day, to make sure they were working properly.

One person showed us their medicine recording sheets and explained that they signed their initials for each tablet the staff gave them, to show that they had taken them properly.

We saw that support staff had worked with the people living in the home to create a new format for describing people's medicines. This helped people understand what their medicines were, what it looked like, as well as how and what time it needed to be taken. This information had been put together using words, symbols and photographs to suit each person's individual method of communication and understanding.

We noted that two people looked after and administered their own medicines, with occasional staff prompts. Specific risk assessments were in place for these people, which helped ensure that they could safely maintain their independence in this area.

The records we looked at, together with discussions with staff and people living in the home, confirmed to us that people had regular reviews of their medicines, to ensure they remained appropriate for their needs.

All staff had received training that was up to date for the safe handling, storage and administration of medication.

Good

Is the service effective?

Our findings

All new members of staff undertook a comprehensive induction process, which included completing essential training courses that would be relevant to their roles. With the exception of very new staff, all staff had achieved diplomas in Health and Social Care and we noted that the staff and manager undertook additional training for areas that were over and above the immediate requirements of the service.

Staff we spoke with told us that they felt very well supported by the manager and the organisation as a whole. Staff told us that they received regular supervision sessions and appraisals and the staff records we looked at confirmed this to be the case.

Other areas that were discussed within the meetings included helping people who lived in the home to arrange and access adult education courses, if they wanted to do them. In addition, people's choices for holidays, activities, general health and safety and promoting people's independence were also discussed.

In recognition of the rise in numbers of people experiencing the early onset of dementia, the provider's in-house training team had begun providing training in this subject. This helped to enable staff to recognise and have a better understanding of dementia, particularly for people who also had a learning disability.

At the time of this inspection, nobody living in the home had any high level healthcare needs. However, we noted that the manager had recently attended a number of 'end-of-life' training sessions and completed training for the Gold Standards Framework (GSF). This meant they were better equipped, with knowledge and understanding, should anyone living in the home ever need this level of support or palliative care.

This assured us that the service constantly strived to ensure people's needs were met in all aspects of their daily lives.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The DoLS are a code of practice to supplement the main Mental Capacity Act 2005 Code of Practice.

We looked at whether the service was applying the DoLS appropriately. These safeguards protect the rights of adults using the services by ensuring that, if there are restrictions on their freedom and liberty, these are assessed by professionals who are trained to assess whether the restriction is needed.

The deputy manager told us that nobody living in Shulas was currently subject to DoLS and we noted that everybody living in the home had been assessed as having capacity to make decisions for themselves. Some people told us that they didn't go out without staff support because they wouldn't be safe on their own. We noted that this was not a restriction on people but something that had been discussed and agreed with them.

People we met and spoke with told us that they always had enough to eat and drink and that they chose the meals for the coming week during their weekly 'tenants' meetings. One person showed us the menu board in the kitchen and said, "This is what we're having tonight – salmon, chips and peas, my favourite!" Two people we spoke with showed us that they had a fridge, cupboard space and a kettle in their room and everyone we spoke with told us that they could make snacks or drinks whenever they wanted.

We saw that the menu board was made up of photographs of each separate food item, for each day. This meant that people could choose exactly what they wanted, such as beans instead of peas or mash instead of chips. Another person, who also showed us the menu board said, "The pictures help us choose what we want and help us remember what things are called. We have a cooked breakfast tomorrow, I really like that".

We saw that, where needed, people received input, advice and support from relevant health professionals such as the dietician or speech and language team in respect of their dietary or nutritional health needs.

We saw evidence in people's care records that showed how some people were supported to manage their weight by understanding and following 'healthy eating' options. We also noted that some people, who had diabetes, were helped to understand their condition and encouraged to avoid food choices that were not good for them. People's individual or cultural choices were also fully respected. For example, where people had chosen to be vegetarian.

One person told us that they were going for a medical appointment during the afternoon of our inspection and

Good

Is the service effective?

said, “I’ve got a few problems with my health so I need to see the doctor quite a lot”. All three people we spoke with told us that they saw people such as the doctor, dentist and optician whenever they needed to.

We noted that the staff and management team had been working closely with the NHS and had developed a working document that contained relevant, important and personal information for each of the people living in Shulas and its sister home. This information would be available for hospital staff, in the event a person was admitted to hospital. This would help ensure people’s individual needs could be met more effectively during their stay in hospital and provide people with more consistent care and support.

Outstanding ☆

Is the service caring?

Our findings

We observed that staff interacted with people in a natural, warm and friendly manner and there was a lot of joviality throughout our whole inspection. We saw that people were comfortable in the presence of all members of staff and we noted that staff listened to people properly and gave their full attention, when being spoken to.

People we spoke with told us that the staff knew them really well. One person told us, "I don't know where I'd be without them [staff]. I sometimes have a few problems and I've had other problems in the past but the staff here are really good and look after us really well." This person also said, "I sometimes feel a bit upset and want to talk. I talk to the staff whenever I want to; I talk to them a lot."

When we asked another person how they felt about the staff, they replied: "They're great, fantastic! They care a lot about us here you know." One person showed us the new television set in their room and told us, "I chose this one and I really like it. Look, [staff] made it safe for me…. …I couldn't open the drawers but staff helped me to fix it so the wire's at the back of the drawers now."

Everyone we spoke with told us that they were fully involved in planning their own care and that they had regular contact with their friends and family members. All the care records we looked at reflected people's personal histories and preferences so that staff could support them with their preferred lifestyle.

Although nobody living in Shulas currently needed to use an advocacy service, the deputy manager explained that this was something that people were supported to access as and when needed.

Through discussions with people living in the home and observations, we saw that people's privacy, dignity, individuality and independence was highly respected. People told us that they were "very" happy with their rooms and two people showed us how they had furnished and decorated them in the way they liked. One person said, "I like my room, I can relax when I want and I like to do my colouring or watch the telly". Another person said, "I like my chair, I watch the people down there (in the street below) and I like watching the dustmen on Mondays. I keep everything nice and tidy in my room; I've got all my things in here…"

We saw numerous examples of how people living in Shulas were constantly supported to enhance and maintain their independence. For example, each person took responsibility for cleaning their own rooms, with individual levels of staff support, according to their needs. People also assisted with household tasks such as washing and drying up and preparing meals.

Other areas in which we saw that people were supported to be as independent as possible included using public transport alone, learning and understanding road safety, meeting with friends and socialising.

In addition, we noted that it had been of great importance for one person living in the home to be able to keep a pet and we saw that they had been supported to do this. The person was able to have full responsibility for their pet's welfare and had also compiled a care plan for it with staff. This gave the person a great deal of pleasure and helped enhance their overall wellbeing.

Good

Is the service responsive?

Our findings

All the people we met and spoke with confirmed that they were involved in planning their care and that they had regular meetings individually with staff to make sure that their care arrangements were still appropriate. One person told us, "We [person and staff] talk about what I do and look at the books in my box to make them up to date." This person also told us, "We have meetings all together every week and talk about what we've been doing."

All our observations and discussions with people living in the home confirmed that that people were recognised and treated as individuals and that the care and support provided was person centred. The care records we looked at for the people we met were also individual and person centred. The records we saw contained detailed pen pictures, personal histories, likes, dislikes and aims/goals for the future.

We saw that, together with the people living in the home, changes and improvements had been made to the format for recording the weekly 'tenants' meetings. Feedback from people living in the home confirmed that they liked the new format and that the use of photographs and fewer written words made the information easier to understand.

We saw that people were able to choose what they wanted to do each day and where they wanted to be. For example, people went to the local church if they wished, attended social clubs and met with friends for lunch or coffees.

There had been fewer adult education courses for people to be able to choose from, due to some cut backs that were beyond the control of the service. However, a member of staff within Shulas and its sister home had recently started an arts and crafts group, which some people we spoke with told us they really enjoyed going to. In addition, some people also chose to attend the horticulture group, which was located at another of the provider's nearby services.

We noted that during the last couple of years, some of the people living in Shulas and its sister home had become more involved in the running of the provider's local horticulture project. In addition, some people had independently instigated successful fundraising campaigns to purchase additional resources, such as a 'poly-tunnel'.

Where people wanted to have personal relationships with people outside the home, we noted they were supported to develop these relationships safely, whilst still maintaining their privacy and independence.

We saw that people's independence was consistently promoted. For example, people were supported with careful risk assessing and planning, to access the community and use public transport independently. We also noted that people were encouraged and supported to carry out household tasks such as cleaning, laundry, meal preparation and cooking.

Everyone we spoke with told us that they knew how to make a complaint if they needed to and that they felt they were listened to and any concerns taken seriously. One person told us, "I haven't got anything to complain about now. I've told staff about things in the past which made me angry or upset and they sorted things out…"

We saw that the home had an appropriate complaints procedure, which contained detailed information about the steps to be taken in the event of a complaint being received. We also saw that people were given a copy of the complaints procedure, which was also available in an 'easy read' picture format. Where possible any complaints were responded to by the manager and resolved at service level but, on occasions, we saw that some concerns had been escalated to one of the directors of the organisation and resolved appropriately.

Good

Is the service well-led?

Our findings

People were regularly able to make their views known during the weekly house meetings and their one-to-one time with staff. The provider also hosted monthly coffee mornings for people's relatives and people using the provider's services could attend regular forums to discuss the services in general, as well as raise and discuss any concerns or issues. Annual quality assurance surveys also gave people further opportunities to provide their feedback regarding the care and support they received. People's feedback was given serious consideration and we noted that any action taken as a result was recorded and reported upon in the service's annual development report.

The notes from some of the regular 'tenants' meetings showed that people living in the home were fully involved in the running of the home, including many aspects relating to the further improvement and development of the service as a whole.

We saw that staff communications were frequent and effective. Regular team meetings took place, that had clear agendas, and detailed minutes were taken each time. These meetings covered all aspects of the service, as well as health and safety issues, staffing levels, staff training, areas of responsibility and the individual support requirements for people living in the home.

At the time of our inspection there was a registered manager in post. This person had been the registered manager for many years, which provided stability with the running of the home as well as for the people who lived there, their relatives and the staff team.

Everyone we spoke with told us that the registered manager was supportive and approachable. Collectively referring to staff and the people living in the home, staff told us that everyone worked together well and were a close team. We also saw that the manager had an 'open door policy' and actively encouraged comments, suggestions and feedback from the people living in the home and their friends and family, as well as from relevant professionals.

The registered manager had reported notifiable events to the CQC as required. (A notification is information about important events the provider must inform us about by law).

We saw that there were a number of systems in place in order to ensure the service provided was regularly monitored. For example, care plans and people's individual assessments in respect of risk, were audited, reviewed and updated regularly. Frequent staff meetings also took place and the staff team as a whole regularly took note of people's comments, thoughts and feelings.

In-depth internal audits were carried out by the provider's senior management team, which checked areas such as safeguarding, medication, health and safety, care plans and the overall environment. We noted that the home did not have any requirements identified, following the provider's latest safeguarding audit.

Regular quality audits were also carried out by the staff and management team within the home and we noted that the home had a dedicated health and safety representative. Management checklists were being completed daily, weekly and monthly, which helped identify any issues, including those relating to health and safety. We saw that where issues were identified, appropriate action was taken promptly.

We were shown how the format of the home's health and safety folder had been revised in order to make it more user friendly and effective. We also noted that the quality of the new system, which had been devised by the staff and management of Shulas, had been recognised by senior management. As a result, the new format was currently being used in other residential services owned by the provider.

This confirmed to us that the service was being well run and that people's needs were being met appropriately.