Shine Partnerships Ltd

Shine 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 was the first inspection of this service. It provides care and support to people with mental health needs who have a forensic history.

The service provides care and support to people living in one house so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a registered manager, which 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 very positive about living at the service. They told us staff were kind and caring and they felt safe living there. Staff understood about safeguarding people from abuse and what to do if they had any concerns.

People's needs were identified and responded to well. The service was very effective at working in co-operation with other organisations to deliver good care and support. This included where people's needs had changed, and where people needed on-going healthcare support.

Risk assessments were drawn up integrating people's views and care records were person centred. People were encouraged to reach their full potential, and were encouraged to volunteer and find paid work. The registered manager told us people were encouraged to 'move on' to independent accommodation from the day they moved in.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems at the service supported this practice.

People living at the service took responsibility for cleaning communal areas with support from staff and the provider ensured people were protected from the spread of infection.

Medicines were safely managed and people were encouraged to administer their own medicines if they were able.

People living at the service, relatives and health and social care professionals all praised the service and were positive about the activities, the environment and the management of the service.

The service was well led by a proactive provider, registered manager and deputy manager providing management cover. Staff told us they felt well supported and could contribute to how the service was run.

Quality audits took place to ensure good standards of care were provided and the electronic care and monitoring system meant that management oversight was prompted and evidenced when incidents occurred.

The provider had a clear vision and credible strategy to deliver high-quality care and support. The strategy was well-embedded at this service. Systems at the service supported continuous learning and improvement.

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. Risk assessments were in place and had been developed with input from people living at the service.

Medicines were safely stored and managed and people were supported to safely administer their own medicines.

There were enough staff to support people's needs and staff were safely recruited.

The provider ensured people were protected from the risk of infection.

Is the service effective?

Good

The service was effective. The service worked in partnership with other organisations to deliver good care and support.

People were at liberty to leave the premises as they wished.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support.

People managed their own food and meals but staff were available to provide support if necessary.

Is the service caring?

Good

The service was caring. People were treated with kindness and respect, and were given emotional support when needed.

People's views were asked in how the service was run.

People's friends and relatives were able to visit and keep in contact without being unnecessarily restricted.

The service promoted people's independence and ensured people's privacy and dignity was respected and promoted.

Is the service responsive?

Good

The service was responsive. People's changing needs were

identified and responded to well.

There were a range of activities at the service and people were encouraged to volunteer and take up paid employment.

People received personalised care that was responsive to their needs.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

Is the service well-led?

Good

The service was well-led. The provider had a clear vision to support people to independence.

Systems at the service supported continuous learning and improvement.

The provider, registered manager and deputy provided pro-active management and were well regarded by all stakeholders

Shine 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 inspection took place on 27 November 2017, and was undertaken by one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their involvement was talking with people using the service to ask them their views of the service.

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often at one of the supported living schemes as part of their managerial roles. We needed to be sure that they would be available for the inspection visit.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make."

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

On the day of the inspection there were nine people living at the service with a tenth person in the process of gradually moving in. Inspection site visit activity started and ended on 27 November 2017. It included a visit to the service to meet people living there, the staff working with them, and to check records kept at the service. We also carried out observations of people's interactions with staff. There were nine people living at the service at the time of our inspection visit with another person in the process of moving in. During the inspection, we spoke with four people using the service, one support staff, the deputy manager who also provided care support to people, and the registered manager.

We reviewed the care records for two people living at the service to see if they were up-to-date and reflective of the care which people received. We also looked at personnel records for two members of staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including staffing rotas and quality assurance processes, to see how the service was run. We checked that essential services to the building had been maintained. We then requested further specific information about the management of the service from the registered manager and deputy manager following our visit.

Good

Is the service safe?

Our findings

We asked people if they felt safe living at the house. People told us "I do", and "Yes." We also asked what people thought about the premises and if their belongings felt safe, we were told "Perfect", and "Yes. Very good." One person said "Secure and safe, I personally don't like the cameras (CCTV), but they have to have them." CCTV was used in the communal areas of the house.

We asked people if they ever felt threatened by the behaviour of other people living at the service. All four people told us "No." Two people told us in their time at the service no-one had become aggressive to other people, it had "Not happened" and "That has not happened before."

There were systems and processes in place to safeguard people from abuse. Staff were trained in safeguarding and could tell us what they would do if a person told them they were being bullied by another person at the service or there was a bruise on a person. Staff also understood what whistle blowing was and what to do if they had any concerns that were not escalated satisfactorily within their own organisation.

We saw evidence of one incident that had occurred in the last 12 months, which had been investigated by service and referred to the care co-ordinator. The care co-ordinator had decided after discussion with the person that a safeguarding alert was not required as the person had the mental capacity to decide not to take it further.

Staff were safely recruited. Criminal checks and references were in place before staff started working with people unsupervised.

The provider ensured medicines were safely managed and stored. The temperature at which medicines were stored was checked daily to ensure they were within safe range. The service offered differing levels of support with medicines. Some people had been assessed as able to self-medicate and so they stored their medicines in their rooms. Staff prompted other people taking their medicines and recorded this. Those who needed administration of medicines received this. People told us "Yeah, I know what my medicine is for." "Yeah, they will explain what it is for and explain side effects as well." We asked if medicines were given on time. People said "Yeah", and "If you forget to come down to take your medicine the staff will come and get you to take it."

To help people become as independent as possible so that they can move on to their own accommodation, there were differing arrangements in place for people to re-order their medicines. Some people liaised directly with the pharmacy and picked up their medicine, for other people the service requested repeat prescriptions and picked them up.

We saw medicines were checked weekly by the night staff and records of the audit and the balance of each stock was logged on the care recording system. The deputy manager carried out a spot check weekly and investigated if there was an imbalance of stocks against record. People had been checked for competency in giving medicines before they were allowed to do this task. One person at the service had a condition that

necessitated being given an injection in an emergency. The registered manager was exploring whether this was a suitable task for staff to carry out and what would be required to assess staff competency. Until this was safely in place the recommendation for staff was to call an ambulance in the event of an emergency.

The service had effective risk assessments in place to ensure people stayed safe. For example there were risk assessments in place regarding people's physical and mental health. These indicated relapse indicators, and each person had a 'prevention of relapse and re-offending plan' which people living at the service had drawn up with staff from the service and other mental health professionals. They contained detailed personalised information including what behaviours they may display when their health was deteriorating but also what they can personally do if they realise they are having a relapse. The plan also stipulated what people did not want to happen in the event of a relapse, and who to contact. The service also had risk assessments related to people's ability to manage medicines, money and their safety. One person had a risk assessment in relation to their support needs in the event of a fire as they had a condition that meant they slept very deeply.

People were protected from the risk of infection by the measures the service had in place. The communal areas of house were clean throughout. Communal areas were cleaned by people living at the service on a rota basis. One person didn't want to clean their own room or the communal areas so the service had supported them to find a cleaner to do the tasks. People were responsible for the cleanliness of their own room however, their rooms were viewed as part of maintenance checks and any significant concerns with hygiene would be addressed if necessary.

We asked people if they thought the service was sufficiently clean. People told us "Yes." "Sometimes we need to clean it." "If you cannot do it yourself they will help you, I do my own room." The registered manager told us "people are moving on from the day they move in." People's ability to maintain a moderate level of cleanliness in their environment was one aspect of a wider assessment of their capacity to live independently.

We asked people if they thought there was enough staff on duty. They told us "Yes there are." And "Anytime two staff on duty, one will stay in the office and the other can go out with person to shops etc, a very good idea." One person told us "Normally enough staff about." On the day of the inspection there were sufficient staff on duty to meet people's needs. There were two staff on duty in the day and one person who slept in at night. The registered manager and deputy re-evaluated staffing requirements depending on people's health and well-being. Management support was available out of hours to support staff working at the service.

We could see from records that there was learning and improvements made when things went wrong. For example, we could see from records that accident and incident events were reviewed by the registered manager. The computer software on which all records for the service were held triggered management input following an incident. Records showed that following an incident earlier in the year the staff had discussed what had happened and what could be improved at the next monthly staff meeting.

Good

Is the service effective?

Our findings

We asked people living at the service if they thought staff had the skills and knowledge to support them. People said, "Definitely", "Yes", and "Yeah."

The service assessed people's needs and choices so that care and support was delivered in line with standards to achieve effective outcomes. Staff were proactive in seeking support for people when their needs changed or when they experienced a period of ill health. For example, one person told us "I am involved, if I deteriorate they will ask me do I want to go to hospital, ask if OK, and I can say if I want to go to hospital or not, I am involved."

Other health and social care professionals were positive about the staff and the service and felt confident it could meet the needs of people they placed there. One professional told us "Staff are well-trained, sensitive, able to provide good feedback when I visit." Another told us they had "great confidence" in the staff as they had good knowledge of the people and their conditions. Health and social professionals also told us the service was quick to let them know if a person's health deteriorated and that they always sought advice if they were not sure of something and worked in partnership with them.

We could see that staff had the skills, knowledge and experience to deliver effective care and support. Staff received a lengthy induction over a month to five weeks, which involved training and working alongside staff. New staff undertook the Care Certificate, a nationally recognised qualification which sets out best practice standards in providing care. Staff were not allowed to work unsupervised until they had completed their three month probationary period.

Staff training took place in key areas including safeguarding, medicines management and competency in giving medicines, food hygiene, breakaway and de-escalation techniques and fire safety.

Staff told us they felt supported in their roles and received regular supervision every two months. One staff member told us it was an opportunity "to let everything out, a destresser." Staff appreciated that their previous skills and experience was valued and the organisation provided them with opportunities to continue to use and develop those skills. For example a trainee occupational therapist working shifts at the service was facilitated to run groups. A staff member told us they were considering undertaking training in a nationally recognised cognitive behavioural course and had been told their shifts would be adjusted to accommodate their continued work at the service whilst studying. The registered manager had been supported by the provider to undertake a postgraduate degree in forensic mental health. In this way the provider valued the staff and focused on retaining them once they were fully trained to carry out the role.

The provider also promoted shared skills across the organisation to share learning and keep staff motivated, and whilst staff worked primarily at one service they undertook shifts at other services if required.

People bought and cooked their own food, and we saw that some people shared their favourite recipes in the monthly newsletter. People had lockable cupboards in the kitchen and allocated areas in the fridge to

store food. People told us "Yeah, I cook for myself and cook with the staff." And "If we want to cook for the whole house we can if we want to." "I don't really like cooking but I like doing deserts." Another said "Sometimes I eat out." We asked people if they minded sharing the kitchen one person said "I don't mind it."

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.

At this service people had full capacity to make decisions and people told us consent was always sought before any support was offered. Consent forms were completed to agree to CCTV in the communal areas. People's tenancies were respected so staff understood they did not have a right to enter people's rooms. Where some people were subject to orders under the Mental Health Act 1983 the staff worked with other health professionals to support compliance. Staff understood their role clearly. For example, if they thought someone may be under the influence of alcohol or drugs and they refused a drugs screen or breathalyser test, the person would be referred to the appropriate mental health professional. We also saw evidence of staff working to a plan set by an external professional to enabled safe withdrawal from excessive alcohol usage.

We asked people if they had visits to or from health professionals. People said "Yes, sure." "My care co-ordinator comes to see me sometimes." "Care co-ordinator and dentist, yeah." We asked if people felt supported to be healthy. People told us "Yes I think so" and "Yes."

To support people with maintaining good physical health their weight and blood pressure were monitored monthly. People were also supported to medical appointments if needed, but the majority of people were able to manage their health themselves. We saw one person had received intensive support with their physical health condition in recent months and a member of the secondary health service was due to attend the next team meeting to discuss with the staff team how best to support this person with their condition. Everyone told us they had their own GP.

Good

Is the service caring?

Our findings

We asked people if staff were kind to people. They told us "Very much so" and "Yes." We saw staff were caring in their approach to people and showed interest in what had happened that day for people.

We asked people if they were helped to keep in contact with friends and family or attend places of worship if they wanted to. People said "Yes", "My family, yes", "I can do if I want to, but I haven't been to church much, went when younger, but have lost interest." Another person said "Yeah I am [in contact with friends and family] and I keep in contact on my own, on social media, if need help staff help me."

People were allowed to have a partner stay over with prior agreement and staff told us people's family and friends visited the house freely. People confirmed this was the case "That's right." "Yes." "Yeah, they are, me, I would rather go to see them."

The service provided free wifi and free access to a digital TV service for each person in their room. There was also a communal TV in the living room.

The service had a goal of enabling people to get on with living their lives in the way they chose. Staff were not intrusive or judgemental in the way they talked with people. Care plans were written in ways that had clearly involved people and documented what was important to them. For example, one said "I would like staff to talk to me every day."

The service also helped people to express their views and be involved in their treatment as far as possible. Care records reflected discussions staff had had with people about their view of factors that contributed to poor mental health in the past. For example, "I was drinking a bit too much." Also, to consider what they could do to make positive choices going forward by thinking about 'high risk thoughts' and 'high risk feelings' and techniques or actions they could take if they had these thoughts and feelings. We asked people if they were involved in their care planning. They said "Yeah." "Well I think I am. I am involved in the planning of my care." One person said "Sometimes." Everyone told us staff listened to them.

Monthly meetings for people living at the service took place. Records showed people talked about a range of things that are commonplace in supported living services, for example, cleaning of communal areas and taking each other's food. However, people also enjoyed doing some activities together and these were discussed, for example, people at the service had asked for a games room to be built in the garden. Funding was made available by the provider and subject to planning permission this would be built in 2018. People also developed a monthly newsletter which had pictures of shared activities they had been involved in or birthday celebrations. For example undertaking car washing, people had raised over £80 for a charitable organisation.

The service had a large garden and there was a covered smoking area out the back. People had recently asked to be able to smoke at the front of the building and this had been agreed.

The provider supported people's dignity, privacy and independence in a number of ways. Staff told us they respected people's rights to their privacy so never expected to be let into their rooms apart from to carry out a maintenance check periodically. They ensured they were respectful in their manner and only discussed issues in a private setting.

The provider supported people to move onto independent accommodation. There was a limited supply of social housing available, and renting privately was not always possible to obtain for people on welfare benefits. To enable people to move out of the supported living scheme, the provider had taken out two tenancies in the company name and then sublet these to people.

People's care records recorded their spiritual, cultural and end of life care wishes. Staff told us they had celebrations throughout the year for differing cultural and religious festivals and facilitated people to access service in the community to meet these needs if they wished. One person had been bought a separate fridge so they could keep their kosher food separately.

Good

Is the service responsive?

Our findings

The service enabled people to receive highly personalised care that was responsive to their needs. Care and support plans were up to date and individualised. They covered a wide range of areas including their mental health support needs, practical support needs and for those who were vulnerable, how to provide support in this area. People were asked about their end of life wishes as part of their support planning.

Health and social care professionals were unanimous in their praise of the service in communicating with them when people's needs changed. They told us the staff were very effective at working in partnership with them and were very accessible. They found the registered manager very responsive to any issues raised. One health and social care professional praised the service in grasping the issues related to one person's immigration status which impacted on the person.

Care records set out clearly how people wanted to be supported. The aim of the service was to support people to move onto accommodation to live independently and aims and goals reflected this. People could choose who their keyworker was and goals were specific and focused. Keyworker sessions took place every three weeks.

People were supported with volunteering and employment opportunities. A number of people were carrying out paid work, and another person was volunteering. Staff assisted people with benefits paperwork to help smooth the transition to work.

There were numerous activities run by the service or people were supported by staff at the service to attend activities locally. For example one person found it difficult to be motivated to do exercise alone but knew they felt better for it. To support this person, the service arranged for a staff member to accompany them to the gym twice a week. Exercise classes were run and there was games equipment for people to use in the garden. People had been supported to go to Cyprus and Morocco on holidays this year.

A health and social care professional noted the activities run by the provider as positive. We asked people if there were enough activities at the service and in the community locally. One person told us there are "A number of different activities we do here, cooking with staff, we do that." Another said "Bingo stuff like that, Connect 4." Another person told us "I do some on my own, then some with staff." The provider and registered manager were keen to link up with other services locally and were liaising with a local voluntary group who support people with mental health needs to use their space to run a 'boxercise' class. The staff supported people to print a monthly newsletter. We saw that people had reviewed local cafes in a recent edition. In this way they helped people develop their IT skills.

People told us they felt able to make a complaint, and knew how to do so, but they told us they had not felt the need to do so formally. We saw the provider had a complaints policy which set out what would happen in the event of a complaint including timescales for response. The complaints log showed the issues raised by people in the last year, how they were resolved along with the date they were resolved. We saw the staff noted people's verbal complaints on the log so whilst people had not formally complained the service had

dealt with them as though they were. For example, people were unhappy that food had gone missing from the fridge. As a result, people were offered money to replace the food and locks were put on cupboards in the kitchen.

Good

Is the service well-led?

Our findings

There was a clear vision and credible strategy to deliver high-quality care and support, and service was well led in a number of ways. Audits took place in key areas including cleanliness, medicines, care records and building safety. Staff were regularly supervised and told us they enjoyed working at the service. It was positive that the registered manager was keen to draw on staff skills and validate their work and life experience gained either prior to them working at the service or from educational or vocational courses they were taking whilst working for the provider.

There were numerous examples of how the provider, registered manager and deputy manager engaged and involved people who used the service, staff and other stakeholders. We asked people if they had a chance to say how the service was run. They told us "Yes", "We are yeah." People told us "We have a tenants meeting once a month." "We discuss what needs to be done what hasn't been done, we discuss outings, cinema, bowling, snooker, not everyone likes snooker." Another person told us they can "Talk about if we have any problems, talk about days out for the house, say what we like to say."

Staff were able to contribute to the way the service was run in a number of ways. Staff told us that they drew up the rota amongst themselves and ensured their holidays were covered. They tended to work set days so this meant they could plan ahead. They were able to draw on staff from other services when needed and the deputy manager and registered manager ensured there was enough support for newly employed staff.

Staff also told us their views were valued when considering how best to support people. One staff member said they would send an e mail to all staff working at the service if they had an idea or would put it on the agenda for discussion at the staff meeting. Another said they enjoyed the "freedom to make decisions" and had made suggestions to improve the paperwork which had been adopted by the service.

Monthly staff meetings took place and we could see that they covered a range of issues including practical issues, a case study and how best to work with people.

In order to get the views of all stakeholders the provider had commissioned an external organisation to collate feedback on the service. We read 13 reviews that had been posted since the beginning of January 2017. Six were from people living at the service. The majority were very positive about the service, only one was less so. Two family members had also given the maximum rating for the service and noted the long standing staff and excellent accommodation.
People we spoke with on the day of the inspection were very positive about the service and the staff.
The registered manager was well thought of by the people living at the service, the staff and health and social care professionals. We asked people living if they thought the service was well run. They told us "I should say so, yes" and "Yes." Another person said it is "Run very efficiently." We asked people if they would recommend the service to other people. They told us "Obviously" and "Yes I would." Another person said "Maybe yeah, only if they are ill, know what I mean." They told us they were "Very happy, but I want to move on, don't want to stay here very long."

Health and social care professionals were unanimous in their praise of Shine House. The registered manager had recently been awarded The Home Care Registered Manager Award 2017 (London) by the Great British Care Awards.

The provider had introduced an electronic care system. This was positive for the service as people's care records, quality audits, health and safety records and all staff records were contained in an electronic format. This meant that staff could update and access care records easily, and share information quickly. Also the management team could log on from outside of the location to carry out quality checks.

The provider told us via the Provider Information Return that they were in the process of finalising a new outcomes model which would allow staff and people living at the service to focus the service better. This would also become a key source of information to enable improved decision making from a multi-disciplinary perspective. The provider was also employing someone who previously used the service from early in 2018 as an 'expert by experience' within their own service to provide support to people using the service and participate in training of staff.