J S. Care Limited

Mellieha

Inspection report

Hillfold
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Tel: 07961769938

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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

The inspection took place on 13 April 2016 and was unannounced. This was the first inspection of the home since its registration in 2015. Mellieha is one of three homes registered to this provider.

Mellieha is registered to provide accommodation for up to six people with learning disabilities. There were six people living at the home at the time of our inspection.

There was a registered manager in post who was also the provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Staff demonstrated safe practice and had a good understanding of how to keep people safe, with regard for the safeguarding and whistleblowing procedures. Procedures for safeguarding people were followed promptly and the provider worked closely with other agencies where concerns arose.

Staffing levels were supportive of people's needs and flexible to support people to spontaneously go on local outings, as they wished to.

Staff had regular opportunities to update their skills and professional development. Staff demonstrated an understanding of the impact of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), although decisions made in people's best interests were not always clearly documented.

There was a homely, welcoming atmosphere and people experienced good quality interactions from kind and caring staff.

Staff worked well as a team and felt supported by managers and the organisation.

Care records contained clear information covering all aspects of people's individualised care and support, although these were not formatted in a person-centred way and some contained inaccurate information.

People felt supported to complain if they were unhappy about any aspect of their care and there was plenty of information for people to understand.

There were developing systems for auditing the quality of the provision. There was a clearly defined management structure so that all staff knew who was in charge of the running of the home. There was an open and transparent culture in which staff felt able to approach managers.

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

Risk assessments were in place and staff understood these.

Staff were confident in their knowledge of how to ensure people were safeguarded against possible abuse.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were given choices in their daily routine and their consent was sought in line with legislation and guidance. Staff understood the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff had regular access to relevant training to enhance their practice.

There were systems in place to support staff.

Is the service caring?

Good

The service was caring.

Staff promoted positive caring relationships with people and were kind, patient and respectful in their approach.

Staff involved people in their care in meaningful ways which were in line with people's abilities.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People's individual preferences were considered in the provision of their care and there was evidence of person centred planning.

Staff facilitated people's choice of activities in planned and

spontaneous ways.

People understood how to make a complaint and the complaints procedure was accessible.

Is the service well-led?

Good

The service was well led.

Systems were in place and being further developed within the organisation to regularly monitor and review the quality of the service.

Communication between staff in all roles was clear and effective.

Documentation to support the running of the home was in place, although lacked attention to detail at times.

Mellieha

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 13 April 2016 and was unannounced.

There was one adult social care inspector. Prior to the inspection we reviewed information from notifications sent to us by the provider and we contacted the local authority.

We spoke with two people who used the service. We spoke with two staff, the area manager, the training manager and the provider. We also spoke with a visiting social worker. We observed how people were cared for, inspected the premises and reviewed care records for two people. We spoke with three people's relatives by telephone and one member of the social work team involved in people's care. We also reviewed documentation, such as maintenance and quality assurance records to show how the service was run.

Good

Is the service safe?

Our findings

People told us or showed us they felt safe. One person said: "Yes I feel safe here. I know if I don't feel safe I can talk to the staff. I have boundaries for my safety and I know what my coping strategies are. They're on my door". The person told us they were aware of their individual risks and how to manage these with support from staff. For example, they said: "I only go in the kitchen with staff because I might hurt myself". We saw one person was reminded by staff they might wish to tie their shoe lace to prevent tripping. People's relatives said they thought their family members were safe at Mellieha. One relative said: "My [family member] is very safe in their care".

Staff demonstrated a good understanding of people's anxiety levels and the need to feel emotionally secure. Where people showed they felt unsettled, staff offered reassuring words and gestures, such as hand holding or one to one attention.

Staff we spoke with had a good understanding of the individual risks to people. For example, where a person needed a high ratio of staff this was known and adhered to. Staff supported and promoted people's independence according to their capabilities. We saw information in people's care records that corresponded with what staff told us about people's abilities. There were clear steps recorded in relation to managing people's individual risks in relation to matters such as fire, food, transport, personal care, medicines, oral care, monies, mood, sleep and family life. This showed staff knew people well and how to manage their care and support safely.
Accidents and incidents were recorded and systems were in place to establish where trends or patterns occurred, for individuals and the organisation. Staff were aware of potential hazards in the environment, such as staircases and kitchen utensils. We saw people did not have unsupervised access to these areas, although it was not clearly documented for each person what the risks would be. There were environmental risk assessments in place for the premises and the grounds and emergency evacuation procedures were known by people and staff. One person told us if they heard the fire alarm they 'would go to the door'. Staff told us there were planned fire drills as well as unexpected ones. People who wished to smoke understood there were designated smoking areas outdoors to ensure people's safety and the reasons for this were reinforced by staff through discussion with people. We saw a 'grab bag' with essential supplies and information for staff to take in the event of an emergency evacuation.

Safeguarding and whistleblowing procedures were in place and known by staff. Staff understood the possible signs of abuse and were confident to report any concerns to their line managers and to the local safeguarding authority where necessary. Where people's behaviours may challenge the service or others, staff were aware of techniques to use to de-escalate potentially harmful situations and to report any incidents, with referrals to safeguarding as required. Staff we spoke with said positive techniques were used routinely and they would only ever use restraint as a last resort if a person was at risk of serious injury. We spoke with a visiting social worker who told us the managers were pro-active in reporting concerns and seeking advice to ensure people were safeguarded.

We asked the provider about the use of CCTV in the home and the policy around this. The provider said the CCTV was only installed in communal areas and this was with the agreement of all of the people who used the service and in consultation with staff. We saw the CCTV was used to ensure people were safely cared for and was viewed by managers and other professionals where necessary, to determine whether people's care was appropriately carried out. For example, where it was not clear how one person had been supported during an incident, the footage was viewed to look at practice and establish where lessons may be learned.

We completed a tour of the premises as part of the inspection. We looked in two people's bedrooms with their permission, bathrooms and various communal living spaces and saw premises were suitable and safe. We saw people's own rooms were adapted to ensure their safety. For example, one person's curtains were attached with detachable fasteners which meant that should the person wish to pull on these, their risk of injury was minimised.

The provider told us they worked closely with the local pharmacy to ensure people's medicines were supplied correctly. We looked at people's medicine administration records (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample check of medicines to account for them. We found records were complete and people had received the medication they had been prescribed.

We found people's medicines were available at the home to administer when they needed them. Medicines were stored in locked cabinets in each person's room. There were individual thermometers to ensure the storage temperature was within recommended limits within the cabinets. We asked a member of staff about the safe handling of medicines to ensure people received the correct medication and they were knowledgeable about the procedures. Staff told us, and we saw from the training matrix, they received training in medication which helped to ensure medicines were given safely. Staff said their competence was checked through observation by line managers.

We looked at information available to staff when people were prescribed medicines for PRN (as required) administration. We found when people were prescribed medicines such as pain relief, clear protocols existed to guide staff as to when PRN medicines should be given. Where topical creams were prescribed it was clear where these should be applied and details were shown on body maps.

We asked about people's ability to self-medicate. We were told that one person independently self-medicated and there was appropriate documentation which supported the person's ability and preference to do so. This demonstrated that staff enabled people to retain independence as far as possible.

Staff recruitment procedures were robust and the provider told us there was no need for them to use agency staff to cover staff absences. They explained there was a bank staff team who worked across the provider's three homes and knew the people well. Where vacancies arose these were advertised locally and through the appropriate use of social media. We looked at two staff recruitment files. We found safe recruitment practices had been followed. For example, reference checks had been completed from two referees and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Staffing levels were appropriate for the needs of people and we saw people received high levels of support. Where people required one to one care and support or close supervision to ensure theirs and other people's safety, we saw this was managed well through effective communication between staff. Staffing levels were based upon people's individual needs and supported people's preferences in the activities they undertook. For example, one person's care record showed they liked to go out spontaneously and would need the

assistance of staff to do so. The provider and members of staff confirmed staffing levels always enabled this to take place.

The home was visibly clean and we saw staff engaged in routine cleaning tasks, such as during food preparation. Staff told us they promoted people's independence in daily living tasks, such as by supporting them to tidy their own rooms. One person told us they tidied their own room, but sometimes needed staff to remind them about this. Staff we spoke with were aware of the need to use personal protective equipment (PPE) and we saw there were adequate supplies around the home.

Good

Is the service effective?

Our findings

People told us they thought staff knew how to do their jobs. One person said: "The staff here are good." Staff we spoke with said they thought people received care from staff who had the right skills and abilities. Relatives we spoke with said: "The staff know what they're doing. They're doing a marvellous job".

Staff said they felt supported to undertake their work and complete relevant training. The training matrix showed mandatory and optional training, which staff had undertaken each aspect of training and when. Staff had completed training in areas the provider deemed mandatory, such as fire safety, mental health, safeguarding and first aid as well as additional relevant optional topics, such as autism, care planning, epilepsy and MAPA (Management of Actual or Potential Aggression). We spoke with the training manager who was new in post. They told us all staff were working towards the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The Skills for Care induction is designed to provide a structured start for new employees to help ensure they are safely able to provide support to people. This helped to ensure staff had up to date skills to enable them to provide effective care and support to people.

The area manager told us systems were in place for staff to engage with their line managers in supervision meetings, although they were looking at ways to increase the frequency of this support and recognised this was an area to develop. Staff we spoke with said the communication with managers was so open and effective, they did not need to wait for a formal supervision meeting to be able to raise any issues. The management team said they monitored staff suitability through observation and had mechanisms in place for ensuring staff's ongoing suitability was managed, such as open and transparent communication and supervision.

Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support. We saw staff sought consent to help people with their needs. We saw staff accurately interpreted the body language that accompanied people's verbal communication to ensure they understood people's needs. For example, when one person did not want to go out with others for lunch, staff acknowledged they had seen the person look angry and turned their face away. Our discussions with staff, people using the service and observed documentation showed consent was sought and was appropriately used to deliver care.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles

of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The area manager told us four people were subject to an authorised DoLS. Where people did not have an authorised DoLS in place, consideration had been given to their mental capacity and advice had been sought from the authorising body.

It was not always clear from people's care records where information had been discussed in people's best interests, where they may lack mental capacity to comprehend the consequences of decisions made. For example, one person's future health needs had been discussed with relevant medical professionals and their family, and whilst this was recorded in daily notes, there was no clear audit trail of how such discussions may inform the decision making process in the person's best interests. The provider was aware that should any decisions need to be made, a clear assessment of the person's mental capacity, along with best interest discussions should be in place.

People told us or showed us with smiles and nods they enjoyed the food in Mellieha. We observed lunch time. We saw people accessed the kitchen to prepare food and drinks, whilst supported and supervised by staff. We saw and staff told us the kitchen door remained locked, but this would always be opened at people's request. Staff said an unlocked kitchen would pose a hazard to all of the people living in the home, although there were no risk assessments within individual files to explain the rationale for this with regard to each person and was potentially a restriction to people's liberty.
Some people preferred to go out for lunch and staff facilitated this. One person did not wish to go out with others for lunch, but later changed their mind and was supported to go out with staff on an individual basis. One person told us they liked the food. They said: "The food's nice, it's better than hospital food." They said the service encouraged 'healthy eating' which they felt was a good thing for them as they said prior to coming to the home their diet had been poor. One relative told us their family member really enjoyed the food and they had been invited to stay for a meal when they visited the home.

The provider told us they had been developing the menus throughout all three of their homes. They said they had done some food tasting with people and staff to determine preferences and we saw they had taken photographs of the prepared foods to create visual menus for people to make more accurate choices.

Staff told us there were no set meal times as this was determined by each person and they worked round individual needs. We saw staff were aware of each person's dietary requirements and they could confidently explain these to us. For example, one person needed to have a soft diet and staff understood what the person could and could not have to eat because there had been liaison with the Speech and Language Therapy (SALT) team. We saw in practice, the person was supported to make their own choices about what they would like to eat and drink. Where the person was unsure what they wanted to drink, staff showed them different choices of herbal tea, which they liked, to help them choose which flavour to have. This showed staff responded to meet people's dietary needs and choices effectively.

People's health needs were managed well and they had access to health professionals depending upon their needs. We saw there was a white board in the office area which highlighted forthcoming appointments, such as for chiropody, hearing, memory and dental clinics. On the day of the inspection, one person was out at the dentist. They told us they had been having some tooth trouble and staff supported them well to see the dentist and to engage in eating more healthily to promote better tooth care and general health.

Good

Is the service caring?

Our findings

People, staff and relatives told us staff in the home were caring. One person said: "It's good here, it's nice". The person told us staff encouraged everyone to get on well with one another and when this did not happen, staff were on hand to support people. Relatives told us they were very happy with the care. One relative said: "I'm very happy. My [family member] gets excellent care. I trust the staff completely". Another relative praised staff's approach to equality. They said: "They have the ability to be caring towards everybody in equal measure, not favouring one over another".

Staff encouraged and supported people to speak in an open and honest way and to share their views with the inspector. Staff gave reassurance and encouragement to enable people to express their views as they wished to.

We observed staff supporting people in a positive way. Some people living at the home had an Autistic Spectrum Disorder (ASD). We saw staff interacted with people with ASD in a structured and therapeutic approach. Staff were aware of some people's need for routine and this was reflected in their care plans. For example, one person's care plan emphasised the importance of a strict routine to that person and the record stated 'must be followed, no parts skipped'. Staff showed us they were developing activity boxes with visual cues to give the necessary structure to people where needed.

Staff recognised when people were feeling anxious and helped people to manage stress. Staff communicated in a way which helped people to understand what was happening in the day. For example, one person was anxious due to the presence of the inspector and staff enabled them to sit in a different area, with a cup of tea and some reassurance until they felt happier.
Staff took time to sit and chat with people and it was clear they knew people very well. Staff engaged in friendly appropriate banter with people, such as when talking about their favourite football teams and one person told us: "We have a laugh together".

Staff's consistent approach ensured people were all included equally in what took place within the home. When one person spoke about going out for lunch, all people were invited to go and staff respected their decisions to go out or stay in. Staff spoke with people in an equal and respectful way with friendly gestures to accompany words and reinforce communication. Where people had less clear verbal communication staff were observant of their body language and facial expressions. When supporting people with their care, staff offered good explanations to enable people to do as much for themselves as possible.

Each bedroom was a single room which gave people privacy. One person's room had a sign on the door that said: 'Welcome to my room. Please knock before entering'. Staff were mindful of people's need for privacy and knocked on every person's door before entering. We saw rooms were personalised with people's own possessions, photographs and personal mementos. This helped to make each room personal and homely for the person concerned. One person told us they liked living at Mellieha and their room was decorated to their taste, with posters of their favourite football team. Another person's room was decorated in their favourite colour.

Good

Is the service responsive?

Our findings

People we spoke with told us care provided was responsive to their individual needs. For example, one person told us they had a care plan and this was reviewed with them monthly. They said: "I'm making progress here". Relatives we spoke with said the service was appropriate for their family members' needs. One relative said: "They know [my family member] well and they do more than they have to do to make sure the care is right. I know everything they do is in [my family member's] best interests and they let [them] do as much as [they] are able for [themselves]". Another relative said: "I know [my family member] is ok because they don't ring me. If they rang me all the time, that's when I'd know the care wasn't right".

All staff we spoke with had a good understanding of the individual needs of people. Staff were able to describe people's personalities, their likes and dislikes and their individual care needs and we saw the information told to us by staff was detailed in individual care records. Staff knew the goals people were working towards and were able to describe how they supported people with these.

Staff understood what was important to a person and made every effort to ensure their well-being. For example, one person had lost their hearing aid and staff made every effort to look for this. Staff remained flexible and responsive to people if they changed their mind about what they wanted to do, or whether they wished to go out.

People decided upon their own activities. One person chose to go out independently for the day and other people chose to go out with staff for lunch. One person preferred to watch television and another person played an indoor game with staff. Staff told us they facilitated people's choices and they were aware some people needed to work within a set routine, whilst other people made spontaneous decisions about activities.

The provider told us when people moved into the home this was done gradually and detailed assessments took place which ensured people's independence was maintained. Care plans recorded what each person could do independently and identified areas where the person required support.

We looked at two care plans and saw each care plan was individually tailored to reflect people's needs. There was detailed care planning where necessary surrounding the management of challenging incidents. Care plans illustrated to staff the positive ways of caring for people to generate the best outcomes of behaviour and at the same time protect staff from possible harm. Care plans also sought to provide boundaries within which each person could function in a constructive way. The boundaries were designed to provide the necessary structure to daily living which some people needed to have in place. One person told us: "I know my boundaries and I know my coping strategies". They said their coping strategies were listed on their door to remind them. The person said: "We talk about my care plan at my monthly review". We saw at the end of each month, each person was involved in a review of their care needs with their key worker.

Whilst we saw care records gave sufficient detail of how people needed to be supported, these were not

organised in a personalised way. For example, the front page information was a body map, whereas the person's own profile would have offered a more individualised introduction to their care and support plan. We saw some people's records contained type errors, such as referring to 'she' as 'he' and we discussed with the provider the need to ensure accuracy, particularly where generic information may be copied between documents.

People we spoke with said they knew how to make a complaint if they were unhappy about the service. One relative we spoke with said they would not know how to complain, but said the staff were 'so approachable' they would not hesitate to speak with one of them if they had any concerns. We saw there was complaints procedure information available in the service to assist people. Staff we spoke with said they would ensure people's views were heard and should people have cause to complain, staff said they would support them to follow the procedure. There was a system in place for recording complaints and compliments. The provider said they were considering how to make information more accessible to people, such as in pictorial and easy-read formats.

Good

Is the service well-led?

Our findings

The registered provider was also the registered manager. There was an area manager who also shared responsibility for the provider's two other homes and rotated between all three, although spent much of their time at Mellieha as this was the newest of the homes, to ensure systems and processes were established. There was a line management structure within the home that staff were familiar with and this included a care manager, who was absent on the day of the inspection, a quality audit manager who was returning from leave, and a training manager who was becoming established in post.

Relatives and other professionals we spoke with told us they felt the service was well run and there was open and transparent communication in place. Care staff told us they thought the home was well run and they felt well supported because all of the managers were involved in people's care. One member of staff said they respected the management team because they would do 'any of the work within the home'.

The values and vision of the service were known by staff who told us they felt confident in their roles and responsibilities. Staff understood who was in charge and said managers encouraged staff to raise any concerns with them at any time should they need to. The management team said they were keen to promote a culture of openness and communication within the home and this was evident as we observed frequent communication between all staff and people who lived at the home.

Staff meetings addressed operational and professional matters, such as medicines audits, cleanliness, fire evacuation, training, shopping and menus. Staff we spoke with said they felt able to contribute to staff meeting discussions. We saw staff meetings had been held in October 2015 and not again until April 2016. Staff said they felt these were frequent enough for the size of the home and managers said they would consider whether these needed to be held more regularly to ensure matters discussed were minuted.

We saw there were measures in place for assessing and monitoring the quality of the service provision. For example, the provider carried out regular audits and produced reports to show where action was required and action taken. Staff and service user satisfaction surveys were carried out. Staff and relatives we spoke with said their views were regularly considered and they felt valued.

Policies and procedures were clearly documented and regularly reviewed, although it was not always clear whether some review dates were dates of done or planned reviews and the provider agreed to record these more clearly.

The provider told us and we saw there were regular safety checks for the premises to ensure the building and utility supplies were suitable. Maintenance records for the premises, vehicles and equipment were up to date, organised appropriately and available for inspection.

Some documentation related to previous legislation, such as the provider's statement of purpose and the quality management procedures. For example, the medication audit referred to the guidance about compliance that pre-dated the fundamental standards for care. The provider said they were considering

ways to bring all policies, procedures and documentation up to date in line with current legislation to ensure best practice in the home.