Kadima Support UK Limited

Kadima Support UK Limited No 300

Inspection report

300 Philip Lane
London
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected this service on 11 October 2016. The inspection was unannounced. Kadima Support UK Limited No 300 is a care home registered for a maximum of seven adults who have mental health and additional complex needs. At the time of our inspection there were seven people living at the service.

The service is located in a large terraced house with access to a back garden.

There is no inspection history for this service as a new provider took over the running of the service in October 2014.

At the time of the inspection there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were administered safely but the temperature for storage was not routinely recorded. This was of concern as the efficacy for some medicines is reduced if they are stored outside of the specified storage temperature range. We also noted a discrepancy between stocks and records for one person living at the service.

Management of money for one person was not effective so they were at risk of abuse.

During the inspection we witnessed staff managing people in a calm and supportive way even when people were at times quite agitated and verbally challenging to them. People using the service informed us they were mostly satisfied with the care and services provided.

Staff had been carefully recruited and we could see that regular supervision took place with the majority of staff. Staff told us they felt supported and management support was available.

The service was clean throughout and we noted that the majority of food was stored and labelled safely in the fridges in the kitchen. People's nutritional needs were met and people chose what was on the menu.

We reviewed risk assessments and care plans for people using the service. These were comprehensive and provided guidance to staff in caring for people living at the service.

With the exception of one person, people went out to social activities and hobbies independently. One person needed support to leave the premises and they had a limited activities programme. Staffing levels were under review at the time of the inspection.

Senior managers undertook quality assurance audits on a three monthly basis. There were quality

monitoring systems in place, although not all of these were effective or taking place in line with the service's procedures at the time of the inspection.

There was a record of essential inspections and maintenance carried out on the premises.

We identified a breach of regulations in relation to medicines management, management of people's money and the governance of the service.

We have made a recommendation in relation to the recording of training for staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Medicines were not managed safely as there was a discrepancy between the record and stocks for one person and the storage temperature was not recorded for any of the medicines.

One person's money was not managed safely.

Risk assessments were in place and provided guidance for staff in managing identified risks.

Staff were safely recruited.

People living at the service told us they felt safe living there.

Is the service effective?

Good

The service was effective. Staff had relevant skills and knowledge to provide care and support to people.

Staff told us they felt supported and records showed the majority of staff were receiving supervision on a regular basis.

People using the service were supported to attend health appointments and health and social care professionals spoke well of the service.

People were supported to have a healthy diet and had choice in menu options.

Is the service caring?

Good

The service was caring. People living at the service told us staff were caring and we observed good interactions between staff and people using the service.

People told us they could give their views as to how the service ran.

People were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive. Care plans gave detailed information on people's needs, and support plans were relevant and updated regularly.

There was evidence of person centred care.

People told us they knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well led. There was a lack of effective quality assurance systems in place at the service.

There was a culture of openness and respect at the service.

Kadima Support UK Limited No 300

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 11 October 2016 and was unannounced. The inspection team comprised of one 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.

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 improvements they plan to make. We also looked at information CQC held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the visit, we spoke with the registered manager and two members of staff, one of whom worked for an agency, but who worked on a regular basis at the service.

We checked medicines storage and records related to medicines. We looked at care records for two people using the service. We talked with three people living at the service.

We looked around the premises including looking at one bedroom occupied by a person living at the service. We looked at records relating to the management of money, medicines and maintenance of the service. We looked at training records for three members of staff and supervision records for five members of staff. We also looked at the recruitment process for two members of staff.

After the visit we spoke with one relative of people who used the service and three health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service. Two people using the service told us how the support that they were offered made them feel safe and respected. One person told us "The staff help me, they know me and I trust them."

Most people living at the service went out independently. Staff at the service told us "We are here to provide support, not to tell people what to do."

Staff understood whistleblowing which is how to raise concerns about poor practice to the employer and outside agencies.

Staff were able to tell us about safeguarding adults and what they would do if there was an incident of concern at the service. We could see that staff had received training in safeguarding adults. Safeguarding records indicated the service had acted appropriately in the majority of instances. For example, they had called the police when necessary and made notifications about safeguarding concerns to the Care Quality Commission and in the majority of cases, to the local authority, as required.
We noted one occasion when the service had not referred an incident to the local authority as the person who had been assaulted did not want the process taken further. We discussed this with the registered manager who undertook to refer to the local authority safeguarding team any incidents relating to a person who lacked capacity. Following the inspection we could tell from records that this process had been followed.

One of the roles the staff had was in negotiating relationships between people living at the service. We witnessed staff gently managing disagreements between people. From safeguarding records we could tell that occasionally disputes erupted between people living at the service, but people did not tell us this was an issue for them.

The service managed one person's money on an informal basis. We checked the documentation to tally expenditure against receipts. As there was no effective system for storing receipts the registered manager was unable to find two receipts we asked to see. The registered manager acknowledged that the system was not robust and was not effectively safeguarding the person's money.

The above concern was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager has implemented a new system for managing people's money which includes a better system for storing receipts.

Risk assessments were in place for people and had been updated recently. We could see that staff were provided with information to mitigate and manage risks identified. We also witnessed staff discussing and promoting safety to one person living at the service by gently offering advice regarding their use of money

and their method of transport before they left the premises.

Incident forms were completed appropriately and reviewed by the manager to ensure remedial action took place and any learning was communicated to staff.

We checked records related to medicines and medicines stocks. We found for one person there was a discrepancy between stocks and the record for one medicine taken as needed (PRN). We discussed this with the registered manager who checked the medicines audit documentation but he could not tell if the recording was inaccurate or a tablet had been mislaid. This was of concern as we could not tell if the person had received an inappropriate dose of medicine.

We noted there were no records of the temperature where medicines were stored. This was a concern as the efficacy of medicines can be affected if stored outside of the specified storage temperature range.

The above concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager undertook to record the temperature at which medicines are stored following the inspection and is aware of the need to undertake remedial action if necessary.

The premises were clean throughout and we could see most food was stored and labelled safely. The care staff were aware of the need to label and seal food and could show us the system they used. The service had obtained the highest rating for food hygiene when last inspected by the Food Standard Agency in 2015. Fridge and freezer temperatures were taken daily to ensure they were within safe limits for storing food.

Essential services such as gas and electricity had been inspected and found to be safe and the environment was odour free. Portable appliance testing (PAT) had been highlighted by senior managers as needing to be undertaken in September 2016, but this had not been completed, due to an oversight by the registered manager. We could see that fire drills and testing of the fire alarm took place on a regular basis.

We could see from the rota there were always two carers on duty between 8am and 9pm and routinely one carer awake at night to support people living at the service. On weekdays the registered manager was also available to offer additional support. Due to a person's complex health condition at the time of the inspection, there were two waking night staff on duty. The registered manager told us that the service employed permanent members of staff and used bank and regular agency staff as required. Staff understood the needs of people living at the service, and staffing requirements could be increased according to the need and appointments of the people living at the service. The agency staff member we spoke with on the day of the inspection told us he was always supported by other staff when he worked a shift and was never employed to work alone at the service. Staffing levels were in the process of being reviewed at the time of the inspection as one person required one to one supervision on an on-going basis.

Recruitment checks, including Disclosure and Barring Service checks, were carried out before staff started working with people. This meant the provider had satisfied themselves staff were considered safe to work with people who used the service.

Good

Is the service effective?

Our findings

Staff had a reflective approach to their work and were able to treat people living at the service in a dignified and respectful way which took into account people's need to be independent and supported, even when they were making unwise decisions.

Staff told us "We are here to work with people over time and to encourage them to make wiser choices. Sometimes people make choices and use behaviours which are not helpful. We are here to show the consequences of such choices, but also work with people so that they can share their feelings around such decisions." Another staff member told us "Sometimes people have coping strategies we might not agree with, but we have to ensure that they feel open to talk about such behaviours and that is important. We have to keep channels of communication open, so people feel confident they can talk to us at any time. I won't say this is easy, but it keeps people trusting us all."

People living at the service told us that staff were able to support them in a way that was useful to them. Two people told us the staff were responsive and supportive during times of crisis and heightened risk. One person also told us "The staff help me; they look after me and manage my [health condition] very well. They take my blood and the GP is not far away. They also help me make my meals, so this helps as well." Another person said "The staff support me and I know I can ask them for advice at any time."

We saw staff de-escalate a situation during the inspection. A staff member sat with the person using the service exploring their needs and concerns without judgement. This was an example of staff displaying skill in managing people with complex mental health needs and a dual diagnosis.

Records showed that staff supervision was taking place regularly, but supervision that was due in September 2016 for some staff had not been undertaken. We asked the registered manager how he reminded himself that supervision was due to take place. He told us he usually used the diary but could not explain why he had missed supervision for staff in September. We could see from records that the registered manager received monthly supervision from his manager.

Staff had received a comprehensive induction which covered key areas including safeguarding adults, administration of medicines, mental health needs and health and safety issues. Staff kept up to date with information by completing refresher training questionnaires on a yearly basis which were then discussed during supervision. Questionnaires were wide ranging and covered safeguarding, whistle blowing, medicines administration, health and safety and issues of capacity. Additional training was also provided through face to face training in key areas. Staff had been able to access training in smoking cessation and motivational interviewing as a registered manager from another Kadima scheme locally was qualified to train in these areas. This was positive as motivational interviewing training is utilised by a number of this provider's services to assist people to embed changes in their lives.

Whilst we could see that this training had taken place records were not held in a format that senior managers could readily access, and check that training had taken place as part of the service quality

assurance process.

One person living at the service had been diagnosed with a condition, although they rarely had a seizure. Staff were able to tell us that they would do if this person had a seizure and we could see from records they had managed a situation appropriately. However, they had not formally received training in managing a person who may have a seizure. The care co-ordinator for this person told us they were confident staff understood how to manage the condition as they had spoken with the staff.

We recommend that training records are stored in a format that is easy to understand and access as part of the quality assurance process and that specific training is provided in managing a person with seizures.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. One person living at the service was being deprived of their liberty as they needed support when leaving the premises.

We noted this person was also having their cigarettes managed by the service and limited to ensure they had sufficient cigarettes to last the whole day. We discussed the lack of documentation to justify this restriction with the registered manager who told us this procedure was in place at the time of the person's admission to the service. Following the inspection the registered manager arranged a best interests meeting to agree management of this person's cigarettes.

Records showed that people accessed a range of health care professionals with the support of the staff. One person told us "The staff make sure my blood is taken and I am looked after. They are very good." This included opticians and dentists as well as GPs and mental health services. Health care professionals told us they were made aware of any changes in people's health and we saw correspondence from the registered manager alerting other professionals to people's changing conditions.

Health and social care professionals told us the service was able to manage people with complex and multiple needs. They were informed when people's health declined and staff worked hard to maximise people's well-being through support and following through on actions agreed by the multidisciplinary team. Two health and social care professionals acknowledged the challenges of people using illicit drugs on the premises and had asked the service to invite the local police to speak with people living at the service. The local community police team attended on the evening of the day of the inspection.

Staff told us that with the exception of one person, people prepared their own breakfast and lunch from a range of foods available at the service. The staff supported people with these meals if required. Dinner was prepared by staff and the menu was agreed by people living at the service. Staff told us sometimes people liked to cook for each other. They told us this was positive as even though they recognised people had different lives, this helped people get on better with each other and helped create better relationships and understanding between people.

We could see that where there were concerns regarding people's weight, remedial action had been taken with positive results.

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The building was not suitable for anybody with significant mobility problems due to the number of stairs. This was not an issue for the people who were using the service as nobody had any mobility problems.

Good

Is the service caring?

Our findings

One person told us "The staff help me, they know me and I trust them." Another person told us "The staff here are generally good. I feel I can open up to them and talk." We saw staff treating people with kindness and sensitivity.

There were positive conversations between staff and people living at the service which were natural and open. For example, by the way in which a person chatted with staff in relation to their complex risky behaviours. We also noted staff did not respond defensively or negatively when people were verbally abusive to them. This was very positive as the environment could have been very tense and intimidating if the staff had responded in a similar way. Instead, their approach was to defuse the situation and try to understand the frustrations of the people living there. In this way we could see staff treated people with dignity and respect.

People told us they were involved in care planning and we could see from records people signed agreements regarding who their information could be shared with when they arrived at the service. There were also signatures of people on the majority of care plans and risk assessments. Where there were no signatures, the staff had written that people had refused to sign documents. Sometimes this was because they did not want to agree to actions which were part of their tenancy conditions.

People's religious beliefs were noted in care records. One person's care plan noted they were to be supported to attend a mosque on Fridays. They had limited interests and this was an important activity for them. The person concerned did not want to talk with us, but this was confirmed by the person's relatives. We noted from daily records that this happened sporadically. Sometimes the care records noted the person was too unwell to attend, on other occasions there was no reason given. We discussed this with the registered manager who told us there was always a Muslim staff member on the rota to support the person to attend the mosque on a Friday. This carer also spoke the person's first language. The registered manager undertook to review this person's attendance at the mosque as it was an important aspect of their life and to maintain accurate records regarding attendance.

We saw one person's bedroom and noted it was personalised. People were encouraged to clean their rooms, do their own laundry and cook their breakfast and lunch where they were able to. People told us they were helped to arrange appointments and where they needed to be accompanied staff were available. The model of support offered at the service was to promote independence as far as possible by encouraging people to increasingly undertake tasks themselves.

Residents' meetings had taken place in May and July 2016 but not since. We asked the registered manager how he got the views of people who lived at the service. He told us through the regular key worker sessions that took place, but acknowledged that these meetings would not cover all the issues that arose when living in a communal house. People did not give us an opinion on whether they thought residents' meetings should take place or how their views should be sought. The registered manager undertook to ask the people living at the service how best to gain their views and told us he would then act on that decision.

Good

Is the service responsive?

Our findings

Care plans were detailed and covered a wide range of areas including management of challenging behaviours, cigarettes, money and epilepsy. Support plans were person centred and individualised. These were updated every three months if a person's needs were stable, daily notes were also completed. For people in crisis, support plans were reviewed monthly and significant events were recorded separately so it was easy for staff to find information in the care records.

Regular key worker sessions took place and we could see that relevant discussions took place to support people in progressing towards their goals. People were encouraged to develop their independence and then progress on to 'move on' accommodation or to living alone in their own accommodation. One person was visiting new accommodation on the day of the inspection and we witnessed communication with another organisation to facilitate a smooth transition to the new property.

The majority of people living at the service were able to go out independently so had their own friendships, families and activities they were involved in. People attended the local recovery college, painting at the local mental health unit and sports facilities locally.

One person needed supervision to leave the building and had a limited range of activities they were involved in. These included going to the park, walking locally and being accompanied to the local mosque and the family home. A relative told us they thought there could be more activities for people who needed support, at the service. Their family member had difficulties using public transport, so the registered manager undertook to apply for a taxi card for this person to facilitate a greater number of activities in the community.

Staff worked co-operatively with people to support them to be independent but also to reduce their social isolation. The service had access to a minivan which meant that people from this service could join other people living at Kadima schemes locally on trips out. We saw that trips had recently taken place to the seaside and Epping Forest.

The house had a garden which was adequately maintained and had seating in a covered area so people could smoke outside in all weathers. The service had a computer for use by people living at the service and information regarding local resources on notice boards was up to date and relevant.

The service had a complaints book but there were no complaints logged in the last 12 months. The complaints process for people living at the service was clearly displayed on the notice board in the hallway on entering the service, and people told us they knew how to make complaints.

Requires Improvement

Is the service well-led?

Our findings

The service provided support to people with complex and multiple mental health needs. This often resulted in behaviours that challenged the service.

We saw elements in which the service was well managed. The service operated on the basis of an open and transparent culture. We observed and witnessed therapeutic conversations relating to risk and safeguarding, which illustrated the confidence of staff and people using the service in talking and working together. The care which was offered provided boundaries but was empathetic.

Staff were skilled in defusing tension and disputes within the service and health and social care professionals spoke well of the service.

Three monthly audits by senior managers looked at areas including the décor and repairs, cleanliness of the home, training, fire safety and quality of the care by talking with people living at the service. We also saw an action plan following the audits to outline areas requiring further action. These included issues relating to records, training and policies and procedures.

We saw the registered manager had undertaken some supervision with staff and audits were carried out on medicines on a frequent basis. Fridge temperatures were taken daily and the service was clean. Staff meetings had taken place on a monthly basis this year and staff told us they felt supported in their role.

However, there were other areas in which the service was not so well led. The registered manager had not been operating a robust system to manage one person's money but the system for managing petty cash was robust and involved sending receipts to head office on a monthly basis. This indicated the registered manager knew the necessity of financial oversight to ensure safe management of money.

The registered manager had devolved the weekly audit of medicines to staff but this had not been undertaken since 12 September 2016 and until we asked to see the documentation he had not been aware it had not been completed. Also, it had not been effective in detecting an error in medicines stocks that had occurred.

We noted that a quality assurance visit by senior managers in July 2016 had noted the PAT testing was due to be undertaken in September 2016 but this had been overlooked. The registered manager had not undertaken supervisions that were due in September 2016. These issues indicated a lack of systems to prompt actions to be taken by the registered manager, even when highlighted by a quality assurance action plan.

These issues of concern were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager acknowledged there were some areas relating to the management of the service

that could be improved and told us he was keen to make these changes. He also made us aware the decline in one person's mental health had been very time consuming for him and the staff and in his view explained why some audits had not been undertaken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe management of medicines. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have a robust system in place to manage people's money. Regulation 13 (1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were insufficient systems and processes established and operated to effectively ensure compliance with requirements of the legislation.