Yad Voezer Limited

Yad Voezer 1

Inspection report

64 Queen Elizabeth's Walk
London
N16 5UX
Tel: 020 8880 2674
Website: www.yadvoezer.com

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection visit took place on 9 December 2014. It was unannounced. At the last inspection in July 2014 we found a breach of the regulations in relation to staff support. On this occasion we found that appropriate steps had been taken to improve staff supervision and appraisal and all staff had started a programme of mandatory training to ensure they had up-to-date skills and knowledge.

The service provides care for eight men with a range of needs associated with learning disabilities and/or mental health issues. Some people have additional physical disabilities. There are two extra bedrooms available for men requiring short term respite care, but no one was using these rooms at the time of our inspection. Bedrooms are located on each of the three floors of the home. Each person has their own bedroom with wash hand basin. A stair-lift is available to the first floor. The service provides support in line with orthodox Jewish custom and practice.

A registered manager was in post. 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

Summary of findings

requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection, the registered manager was also covering for a vacant manager post at the provider's nearby care home for women.

Some areas of the home required repairs and maintenance; whilst major faults had been attended to, smaller issues had not been attended to promptly. We have made a recommendation about this.

The home was tidy, but more attention needed to be given to cleaning hard to reach areas as well as items that were frequently touched such as light switches and chair arms. Some minor pieces of older equipment required replacement as they were hard to clean thoroughly.

Adaptations needed to be made to some of the written policies and procedures to ensure they reflected the particular circumstances of the home. New quality assessment and monitoring procedures had just been introduced. We were not sure that the arrangements in place to complete these tasks were sustainable in the long term so we have made a recommendation about this.

We found that staff had a detailed understanding of the people who used the service. Staff members were caring and respected people's privacy, dignity and religious observances. People told us that the care staff were kind to them. There were some good examples of a thoughtful approach to decision making in line with the requirements of the Mental Capacity Act 2005 and the custom and practice of the orthodox Jewish faith.

There was evidence that medicines were safely administered, although one medicine was not stored appropriately.

Each person had an up-to-date care plan and associated risk assessments in place. These gave a clear picture of people's needs and preferences. Some people needed more support with their communication in order to express their views. We made a recommendation about this.

People were provided with a choice of Kosher food, their evening meals were delivered by a restaurant. People regularly participated in activities they enjoyed, such as horse riding or bowling. They were supported to follow their faith by staff members and volunteers from the local community.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe in all areas, as some specific maintenance and cleaning tasks needed to be carried out. We have made a recommendation about repairs.

Arrangements for the safe administration of medicines were in place, but storage of one medicine needed to be reviewed.

Staff were familiar with safeguarding adults requirements and knew how to use the provider's whistleblowing procedure. There were sufficient staff on duty to meet people's needs.

Is the service effective?

Good

The service was effective. People were supported to access healthcare and they had a choice of Kosher meals; the evening meal was provided by a restaurant.

The registered manager had taken appropriate steps to protect people who did not have capacity to make decisions for themselves in line with the requirements of Mental Capacity Act 2005. The implications for others of restrictions put in place to keep one person safe had been fully considered and addressed.

Staff were undertaking relevant training, such as fire safety and had been instructed in orthodox Jewish custom and practice when necessary. Staff supervision was taking place and an appraisal system was being implemented

Is the service caring?

Good

The service was caring. Staff members worked at developing trusting relationships with the people who used the service. They protected people's privacy and dignity when supporting them and respected their religion and culture.

Is the service responsive?

Requires Improvement

The service was not responsive in every area. We made a recommendation for the provider to seek advice to enhance communication with people who use the service and require support to make their views known.

People attended a range of activities which they enjoyed and their care plans gave a detailed picture of each individual's strengths and needs.

No formal complaints had been recently received by the service. Relatives said any issues were sorted out before a complaint became necessary.

Summary of findings

Is the service well-led?

The service was not well-led in some areas. Generic policies and procedures needed to be adapted to reflect the particular circumstances of the home.

New audit systems had recently been introduced, but there was limited management capacity to assess and monitor the quality of the care provided. We have made a recommendation about these matters.

Requires Improvement

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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 9 December 2014 and was unannounced. Two inspectors carried out this inspection.

During the inspection we spoke with six people who used the service. Two were able to respond to some of our questions directly. We asked questions of five members of staff, including the registered manager, and one volunteer.

We read four people's care files and checked the records for all current staff members; we looked at some of the provider's policies and procedures and a variety of records, including those for medicines administration. We observed medicines being given out and other care practice throughout the day.

The inspection was followed up by phone conversations with three relatives to hear their views on the service. We also spoke with a representative from the local authority who knew the service.

Requires Improvement

Is the service safe?

Our findings

One person told us, "I am not worried about safety in the home, but I do worry about [safety] when I am out."

The premises were in need of some redecoration and repair, the registered manager told us this was planned, but it had not taken place at the time of the inspection. This was needed as there was an uncovered light fitting in one bathroom; cracked tiles in the ground floor kitchen, which impeded proper cleaning; water damage in one area from a previous leak. Other wall coverings and paintwork bore the signs of heavy use and this detracted from the homeliness of the premises. We asked the registered manager to ensure the light fitting was attended to immediately.

Although the home was generally clean and very tidy, more attention needed to be paid to cleaning frequently touched items within the home, such as light switches and arms of chairs, as some of these had fingerprints on them or were sticky to touch. High level cleaning was another area which required attention, particularly extractor fans and the area above the kitchen cupboards. Some small kitchen items were past their best and, as a result, difficult to clean, such as the cutlery drainers. A bath board used to assist people getting in and out of the bath was starting to deteriorate and needed replacement as it was hard to clean thoroughly. There was a cleaning schedule in place and there was evidence that it was being followed, but it did not cover issues such as these.

We observed a shift leader administering medicines using a monitored dosage system supplied by a pharmaceutical chain. Medicines administration records (MAR) contained a photo of the person who required the medicines and a detailed description of each drug, including possible side effects for staff to look out for. MAR charts had been completed correctly and there were safe procedures in place for recording the ordering, receipt, storage and disposal of standard medicines.

One medicine in use for two people was a controlled drug which was exempt from the safe custody regulations and from an entry in the controlled drug register. However, it was kept in a locked cupboard alongside documents and other bits and pieces, which was not best practice.

The service had policies in place to help keep people safe, for example, there was a whistleblowing policy. Staff told us they had not had cause to use it, but one staff member was able to describe how they had referred to a similar policy in a different job. We saw documentary evidence that staff had recently undertaken safeguarding training and the staff members we spoke with confirmed this. Infection control and fire safety training had also taken place since our last inspection.

When we spoke with the men who used the service, one of them was able to tell us that they were not worried about their safety within the home. We observed that people looked comfortable in the presence of the staff on duty. There was information in some of the care plans about how individuals showed distress and we did not witness any signs of this. One person told us of the anti-semitic abuse they sometimes faced when out alone, we saw that there was a risk management plan in place to reduce the likelihood of this.

Some of the people using the service had specific support needs when out in the community to keep them safe. These were well documented in their care plans and the staff we spoke with were fully aware of them. One staff member described how, when outside the home, they had to view the environment from the perspective of the person they were supporting in order to predict possible hazards. They demonstrated detailed knowledge of the sorts of things that might cause a reaction in the person they were supporting. We saw a personalised procedure to keep one person safe and were told about the success of the work that had been undertaken to reduce risks for this individual.

When we checked staff rotas we saw that there were five staff on duty in the mornings and four in the afternoons. Staff members told us this was sufficient to meet people's needs. The provider had established a small bank of staff who could come in at short notice if required and regular staff also worked additional hours to cover absence. We were told it was not normally a problem to cover shifts. At night a member of waking night staff was on duty and one of the day staff, usually the shift leader, slept in. The registered manager or deputy, along with senior staff in the provider's nearby care home for women, operated an on-call rota between them. This ensured that staff had access to management advice at all times.

A safer recruitment policy and procedure had been adopted. It had been used during the recruitment of the

Requires Improvement

Is the service safe?

most recently employed care workers and there was evidence that appropriate checks and references had been taken up . This was confirmed by a representative of the local authority who had also checked.

We saw that an evacuation plan for the building was in place. This included relocation to a culturally appropriate hotel if people had to stay away from the home overnight.

We recommend that the provider seeks advice and guidance in order to establish a timely response to repairs in order of their priority.

Good

Is the service effective?

Our findings

A relative told us, "[The home is] very organised and professional, even though [my family member] has a key worker I can pick up the phone and speak to anyone, they all know him and know what I am talking about."

The provider had contracted with another organisation to ensure all staff members were provided with mandatory training, such as manual handling and fire safety. We saw attendance sheets and certificates to confirm that this training was underway. The registered manager told us that once the mandatory training had been completed for most staff members, further training, specific to the needs of the people who used the service, would take place. Courses on mental health, autism spectrum conditions and similar that would have assisted the staff to better meet people's needs, had not been booked at the time of inspection.

A local authority representative told us that, once the need had been pointed out, the provider's response to improving the training available had been "impressive". One member of staff told us that they were enrolled on a vocational qualification funded by the provider. All non-Jewish staff had been instructed in the customs and practices required within the home and they were able to tell us about these, as well as the procedure they needed to carry out if they made a mistake when following them.

Staff supervision sessions were taking place regularly and staff had been asked for their comments prior to the first appraisal of their performance. We saw that staff had the opportunity to discuss the needs of people who used the service and their own personal development needs.

The registered manager had recently attended the local authority's training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). We noted that DoLS were in place for one person and that requests had been made to local authorities for assistance with assessing the capacity of some other people who used the service when there were doubts about their ability to understand certain decisions related to their care or treatment. One person who had been assessed to have capacity to make his own decisions sometimes engaged in risky behaviour. We saw that staff had worked with the local authority and local community organisations to reduce risks whilst respecting his rights as an adult. When Lasting Powers of Attorney (LPA) were in place for an individual this was recorded and the registered manager and other staff liaised with the LPA in order to ensure the needs of the person who used the service were met.

As a result of the DoLS which were in place, a keypad had been installed to prevent a person from leaving the building unnoticed. Other people who used the service had been given the code and we saw one or two making use of it when going out.

People living in the home were provided with a Kosher diet in line with the Jewish faith. The service had a current four star food hygiene rating (five stars being the highest). Staff members prepared breakfast and lunch and the evening meal was provided by a Jewish restaurant. We observed that on arrival from the restaurant, the food was reheated until it was piping hot. Non-Jewish staff members had been instructed in keeping a Kosher kitchen and, if there were certain tasks they could not carry out, they sought assistance. Ingredients were bought from Kosher suppliers and on the day of our inspection we met one person who used the service returning from food shopping with staff. He was fully engaged in unloading the car and helping to sort the food. The main kitchen was organised as two kitchens in one – one side for meat, the other for milk products. There was a separate kitchen upstairs which was only used for the Passover festival.

We saw that people were encouraged to choose from the menus provided and pictures were in use to assist them. When we spoke to staff members they were able to speak in great detail about people's individual likes and dislikes, down to how one person liked their crackers laid out. We saw that when fortified drinks were prescribed for one person, staff considered how they would impact on the person's self-imposed routines around food and drink and developed a strategy to help them to take them as prescribed. People's weights were normally monitored on a monthly basis so that any significant changes could be reported to the GP. However, there had been a recent gap due to the absence of the member of staff responsible and there was no arrangement in place to cover this task.

There was evidence that people had received support from appropriate healthcare professionals, such as the local epilepsy nurse, when required. We heard that one person was to receive new glasses the next day following an

Good

Is the service effective?

optician's appointment and we saw photo cards had been prepared by a speech and language therapist for one person to aid communication, although these were no longer in regular use.

Good

Is the service caring?

Our findings

People who used the service told us, “The staff are fine” and “The staff help me if I need help”. A relative said, “The staff try to create a harmonious family atmosphere.” Another relative told us, “I think [my family member] is well cared for.” A third relative said, “[My family member] has a good keyworker.”

We saw staff treating people with respect and protecting their dignity, for example, knocking before opening any closed bedroom or bathroom door and speaking to them politely and kindly. They were respectful of their religious observances and these were promoted through the use of volunteers and local community links.

The staff team took steps to develop trust between people who used the service and themselves. We were told about the process used to build up people’s trust in new staff members’ ability to administer medicines once they had been trained. This started with people getting used to seeing the new staff member standing by the open medicines cabinet. A staff member described the body language that one person displayed when they started to trust new people.

In order to promote their independence, many of the people who used the service were involved in small household tasks within the home and this was reflected within their care plans. For example, one person had responsibility for laying the table. People’s strengths and needs were taken into account when allocating tasks.

We saw evidence that the staff team arranged activities of daily living to take account of individuals’ needs; they did not expect them to simply fit in with the routines of the home. We saw this demonstrated at lunch time when there were specific arrangements in place for those who found it difficult to eat with others. This was achieved with the minimum of fuss so attention was not drawn to the individual, nor was their anxiety heightened.

Requires Improvement

Is the service responsive?

Our findings

One person who used the service said, “They [the staff team] would listen to me if I had a problem.” He also told us, “I choose what I buy.” A relative said, “Quite a few activities are arranged.” When asked how staff responded if concerns about care were raised, a relative told us, “I haven’t had to raise anything big, but they respond well if I ask about small things.”

People attended activities which were matched to their interests. One person gave us a detailed description of their day; it was clear from their enthusiasm that they had enjoyed themselves at a day centre. Other people attended horse riding or went to synagogue whilst we were there. When we looked at people’s activity schedules we saw that this was a typical day. When at home people played board games, watched the news and sport on television or engaged in religious activities. A filter was in place and access to the television was monitored by staff to ensure that only culturally appropriate programmes were shown. This was in line with the faith observed by people living in the home. Some people who used the service had autistic spectrum conditions and their anxiety levels may have been reduced if their spare time was more structured.

More attention needed to be paid to small things within the home, for example, many curtains were hanging off the rails. This was not extensive enough to compromise people’s privacy, but curtains also keep light out and heat in. At least one person was very sensitive to the amount of light in their bedroom.

When we checked people’s care files, although they could have been better organised, we found they conveyed a real sense of each person’s strengths and needs. Records showed that staff adapted their care practice to each person. One person who used the service kept his own daily record which staff members added to on occasion. He set a high standard for accurate, legible recording. This was a good example of involving someone in their own care and support.

People were offered choices within what was acceptable to their faith. We saw that when one person had wanted to take up a hobby which was not acceptable, a best interests meeting had been held and the person had joined an external therapeutic programme which incorporated aspects of this hobby.

Monthly residents’ meetings were held. From the minutes we noted that only two people were regular contributors to the meeting. This was because others needed more assistance with communication. Although many staff members knew the people who used the service very well they ran the risk of making assumptions about how they felt about things. More consistent use of alternative and augmentative communication (AAC) methods, such as photos or Makaton signs and symbols, would enable staff to check out their assumptions and give people more opportunity to express themselves.

There was a complaints procedure in place and it was displayed on a noticeboard. People who used the service would benefit from an easy-read version as it was not accessible to most of them. There had been no recent complaints about the service and relatives told us any issues were sorted out informally before the need for a complaint arose.

We recommend that the provider seeks advice and guidance from a reputable source to enhance communication with people who use the service and require support to express their views.

Requires Improvement

Is the service well-led?

Our findings

A relative told us, “My family are very happy about the way [staff] look after our [family member]”

The service had achieved Investors in People status in 2012, but the provider had been without a service manager for over a year. The service manager line managed the registered manager. We found that this, together with the time spent by the registered manager covering the manager vacancy at the provider’s care home for women, had impacted on the smooth running of the home. It had limited the ability of the provider to keep policies and procedures up-to-date and had the potential to impact on recently introduced quality assurance activities.

The provider subscribed to an organisation which supplied them with policies and procedures and annual updates, but these needed to be adapted for local use and did not always reflect changes in legislation quickly enough. As a result some policies and procedures were not in line with current legislation and guidance, for example, the Mental Capacity Act 2005 policy did not reflect the supreme court judgement on Deprivation of Liberty Safeguards. We saw evidence that the registered manager had started to adapt and implement several policies and procedures, for example, in relation to training, but this was still a work in progress.

Staff told us that management carried out regular checks to ensure that records were up-to-date, although few documents were countersigned to evidence this. Two weeks prior to the inspection visit some new audit tools had been put in place to assess and monitor the quality of service provision. This was on the recommendation of the local authority. The tools had the potential to be useful if the outcomes were analysed, evaluated and lessons, if any, were learned. However, at the time of inspection, due to vacancies, there was little management capacity to carry out these tasks, although they had been started.

There were quarterly staff meetings and the minutes showed that relevant matters were discussed. The local authority confirmed that the registered manager was attending their forums and events to keep abreast of developments in care and was bringing another staff member with him on occasion.

Handover meetings between each shift followed a structured format and handover notes were made. There was a formal handover of responsibility for medicines.

We saw there were very strong links with the local community. Some members directly assisted the home, for example, by providing the stair-lift.

We recommend that the provider seeks support from a reputable source to ensure that the quality monitoring now in place and the adaptations to policy and procedures are sustained and enhanced.