Kadima Support UK Limited

Kadima Support UK Limited No 7

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on the 25 and 27 August 2015. This was the first inspection of the service since it registered with the Care Quality Commission on 17 October 2014, having been previously owned and managed by a different provider. Kadima Support UK Limited No.7 is registered to provide care and accommodation for up to five people with mental health problems. The service was at full occupancy at the time of our inspection and all of the people using the service were male.

There are five single occupancy bedrooms. There is a communal sitting room, kitchen, bathrooms, toilets and a conservatory where smoking is permitted. The rear garden and courtyard is shared with Kadima Support UK Limited No. 7a, which is registered to provide care and accommodation for up to four people with mental health problems.

There was a registered manager in post, who managed both No.7 and No.7a. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

manage the service. Like registered providers, they 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 and their relatives told us they were happy with the service. They said it was a safe place to live with supportive staff.

There were systems in place to identify and mitigate any risks to people's safety and wellbeing, although the service needed to further develop the crisis management plans.

Sufficient staff were deployed to meet people's needs. Staff recruitment had been carried out by the previous provider and did not demonstrate rigorous systems to ensure references were authentic. The provider was aware of their responsibilities with the recruitment of new staff.

Staff received formal supervision and an annual appraisal. Staff told us they had enjoyed the recently introduced programme of training, which focused upon how to meet the needs of people with mental health problems. However, we found that staff knowledge needed to be developed in regards to how to support people with their recovery.

Medicines were safely stored and protocols had been established to make sure medicines were safely administered.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report upon our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others. We found that staff understood how to protect people's rights and no person was subject to a DoLS authorisation.

People's needs had been assessed, and support plans had been developed in consultation with people. The support plans were well written but contained insufficient information about how to support people with their recovery.

People took part in some food preparation and cooking. However, we did not find sufficient evidence during our observations, and discussion with people and staff, that people were being supported to get involved in more activities of daily living. For example, food shopping and household chores.

Complaints and comments from people using the service and their relatives were properly investigated. Information about how to make a complaint was prominently displayed. People had been provided with verbal information about advocacy services to support them to express their views and comment upon services they received.

People told us the service was well managed. There were systems in place to audit support plans, staff training and support records, and health and safety checks. The registered manager was supported by other registered managers within the organisation, but there was no clear system for the provider to carry out detailed and meaningful audits and support the registered manager to improve the quality of the service.

We have made four recommendations. These are in regards to staff receiving training about the recovery model, for people and their representatives to be provided with comprehensive written information about advocacy services, and for support plans to demonstrate how people are being supported with achieving more independence with daily living activities. The final recommendation is for the provider to carry out detailed monitoring visits, which provide professional support and guidance for the registered manager.

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 consistently safe.

Individual risks for people had been assessed as part of the care and support planning process; however, crisis management plans needed more development.

Staff understood how to identify and report abuse, in order to protect people.

Sufficient staff were deployed and the provider was aware of how to safely recruit new staff.

Medicines were safely stored and administered as prescribed.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff received training, guidance and support. However, some staff did not demonstrate an understanding of how to work effectively within the recovery model.

Staff understood about Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA), which meant they could take appropriate actions to ensure the protection of people's rights.

People were consulted about their food preferences and were supported with menu planning and cooking.

There was good liaison in place with people's health care services and people were supported to meet their health care needs.

Is the service caring?

Requires improvement

The service was not consistently caring.

People and their relatives told us they were happy living at the service and liked the staff.

Observations showed that staff interacted well with people and developed positive relationships.

People had been provided with verbal information about independent advocacy services but did not have written guidance which verified the official contact details.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's support needs were assessed and reviewed. We found staff were

Summary of findings

knowledgeable on people's needs but had less knowledge about how to support people with their recovery.

People were supported to access activities in the community; however, they needed more support to participate in activities of daily living, such as food shopping and cooking.

There was a complaints system in place and people's complaints were appropriately investigated.

Is the service well-led?

Requires improvement

The service was not consistently well led.

People and their relatives felt the service was well managed.

Although there was a registered manager in post, the provider did not have a robust system to support the registered manager.

There were systems in place for monitoring and improving upon the quality of the service, which included quality assurance surveys to listen to the views of people who use the service and the monitoring of accidents and incidents to identify any trends that needed to be addressed. However, the monitoring reports by the provider lacked sufficient information.

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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 checked whether the registered provider was 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.

The inspection took place on 25 and 27 August 2015. The inspection was unannounced on the first day and we informed the service that we would be returning on the second day.

The inspection team consisted of an inspector and a specialist professional advisor (SPA). The SPA had a background in mental health nursing.

Prior to the inspection we reviewed information we held about the home, which included notifications of significant incidents reported to Care Quality Commission.

We spoke with two people who used the service, two members of the support staff, the deputy manager and the registered manager. We spoke with the relatives of two people after the inspection. We observed the support and care provided to people in the communal areas and looked around the premises. One person showed us their bedroom.

We reviewed three care plans and the accompanying risk assessments. We also looked at a range of documents including four staff records, the complaints log, the safeguarding policy and procedure, medicine administration record (MAR) sheets, health and safety records, and quality assurance audits.

We contacted health and social care professionals with knowledge of this service in order to find out their views about the quality of the service. We received feedback from three professionals.

Requires improvement

Is the service safe?

Our findings

People who used the service told us they always felt safe living at their home. One person told us, "Yes, I feel safe here" and another person nodded in agreement when we asked if they felt safe. We observed staff interacting in a positive and supportive manner with people. For example one person regularly sought reassurance and information from the deputy manager and other members of staff, and they were responded to in a friendly and encouraging manner. The person confirmed to us that there was always a helpful 'open door' approach if they wished to speak with the registered manager and deputy manager.

The provider had safeguarding policies and procedures, which staff were knowledgeable about. Staff gave us examples of the types of abuse that could occur and explained how they would document and report abuse. Staff were familiar with the provider's whistle blowing policy and procedure, and how to use it. The whistle blowing policy and procedure contained information about how to report concerns regarding the conduct of employees to the provider and to external organisations. We noted that the provider had appropriately informed the Care Quality Commission of any incidents events that were notifiable, in accordance to legislation.

We saw there were systems in place for identifying and managing risks, in order to keep people safe. People's care plans had risk assessments which addressed issues such as substance abuse, absconding and other behaviours that challenge the service. We found that the risk assessments were well written, however the crisis management plans needed more development, in order to demonstrate how the provider would respond to and manage care for people experiencing a mental health crisis.

On both days of the inspection we saw there were sufficient numbers of staff to keep people safe and meet their needs. The deputy manager told us that the staffing levels were arranged in accordance to people's needs and were kept under review. The staffing rotas showed that more staff could be rostered if people needed support to attend meetings and appointments, or if staff needed to visit a person who had been admitted to hospital. The staff we spoke with told us they thought there were always enough staff on each shift.

The recruitment procedures demonstrated that appropriate employment checks were carried out, which included clearance to work from the Disclosure and Barring Service (DBS), proof of identity, two references and checks to ensure people were eligible to work in the UK. We found that although references from previous employers had company stamps or stationary, the provider had not recorded that the references had been verified for their authenticity. This meant people may not have been protected as robustly as possible from the risk of receiving care and support from staff who were not suitable for employment at the service. We discussed this with the provider, who told us that most of the recruitment had been carried out by the organisation that previously owned the service and any new recruitment would demonstrate more rigorous systems for verifying references.

We checked the arrangements for managing medicines, which included the storage, handling, disposal and documentation of medicines for three people living at the service. We found that medicines were stored safely at the advised temperatures and the medicines administration record (MAR) charts were correctly completed. The deputy manager showed us how they carried out regular audits to check medicines were being given in accordance to the prescribers' instructions.

The environment was appropriately maintained. The building was free from any unpleasant odours and the communal areas were clean. The provider employed a part-time cleaner, who we met on both days of the inspection. The kitchen and communal toilets were equipped with hand gel and disposable towels, to enable people to maintain their hygiene. Fire-fighting equipment and alarms, electrical installations, portable electrical equipment and gas safety had been appropriately tested. This helped to ensure the premises was maintained and safe for people.

Requires improvement

Is the service effective?

Our findings

People told us staff respected their wishes and decisions. Comments from people using the service included, "I like it here" and "it's okay, staff are good to me." A relative told us they were "very pleased" with the care and support given to the family member. They described their family member as being "happy, contented and definitely more settled than anywhere else he has lived."

Staff told us they received training that was relevant for their role and responsibilities. The training records showed that staff had completed a range of training, which included mandatory training and other training that addressed the health care needs of people using the service. One member of the support staff told us they had worked at the No.7 and No.7a for seven years, having previously been employed by the organisation that formerly owned the service. The staff member said they had achieved national qualifications in health and social care at levels two and three, which gave them confidence to sometimes take charge of the service in the absence of the registered manager and the deputy manager. They told us their mandatory training included safeguarding vulnerable adults, infection control, medicines management, understanding the Mental Capacity Act 2005 and fire safety. They had also attended training this year about healthy eating and how to communicate effectively with people with mental health needs. We saw there was also training available about understanding the needs of people with schizophrenia, which the staff member had not yet undertaken.

We received information from two professionals that staff were not committed to using the rehabilitation and recovery model. We spoke with two members of staff about this model and found they did not have the level of knowledge we anticipated. We did not find evidence of staff training about using the recovery model, which meant staff did not have the knowledge and skills to effectively support people with their recovery.

Records showed staff had received regular supervision and staff said they felt well supported by the management team. Staff told us they received one-to-one formal supervision every six weeks and an annual appraisal, although the supervision notes we saw indicated the frequency of supervision for some staff was eight to twelve weeks. One member of staff told us they had worked at No.7 and No.7a for over three years and the management team had supported them to gain the skills and knowledge to apply for a health care degree.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and they make sure that where a person may be deprived of their liberty, the least restrictive option is taken.

The management and support staff demonstrated an understanding of their responsibilities under the MCA and knew that decisions should be made for people in their best interests if the person could not make decisions for themselves. The deputy manager told us that all of the people who lived at the service at the time of our inspection had the capacity to make their own decision. The deputy manager said that no person currently needed an application for a DoLS, and demonstrated an understanding of how to apply to the local supervisory body in the event of a person requiring an assessment to deprive them of their liberty. We did not observe people being restricted and/or their liberty deprived due to staff practices.

One person told us they liked the food. People's nutritional needs had been assessed and were recorded in their care plans. Staff told us they encouraged people to eat healthily, which people confirmed. Staff informed us that some people jointly planned and cooked their meals with staff.

We received comments from two professionals in regard to their observations that they have found the fridge empty, the kitchen restricted and cooking equipment locked away. On the first day of the inspection we arrived at 9.20 am and met people in the middle of preparing their breakfasts, which included cooked breakfast items. People told us they could access food and cooking equipment in accordance with their wishes. We observed that the kitchen fridge was quite bare, apart from basic items such as milk, cheese and margarine. A member of the support staff told us they were due to go out shopping for groceries, which was observed to occur later in the morning. We asked people if they went out with staff on the shopping trips and found there was no interest in this activity. The support staff member and the

Requires improvement

Is the service effective?

deputy manager explained that food shopping took place on most days, to take into account people's preferences for lunch and the evening meal and as a measure. Records showed that people were consulted about the forthcoming menu during the residents meetings.

The registered manager described the well-being of people as "the most important factor in the recovery journey." Records demonstrated that people were registered with a GP and received care from other professionals, such as dentists, opticians and community mental health nurses. The care plans included assessments in relation to people's mental and physical health needs, and indicated there were good links with local mental health services and primary care services. People had regular physical health checks and records showed that staff monitored people's weight every month to check for any pattern of loss or gain of concern to their health. Staff told us they had a good relationship with health and social care professionals at the local community mental health team and at other health care settings, such as GP practices. People were accompanied to appointments if they needed or requested this support.

We recommend the provider seeks guidance from a reputable source to support staff to gain more knowledge and skills in regards to supporting people with their recovery.

Requires improvement

Is the service caring?

Our findings

People told us they liked living at the service. One person said, “It’s good, they feed me” and another person told us they were happy. A relative told us, “Staff are kind and caring, not just to people but their families too.”

The deputy manager told us people were asked to get involved in planning their own support and care, and were offered a copy of their support plan. We found that some people were aware of their objectives and confirmed why it was important for them. There was evidence of a caring environment at the service. Staff seemed to understand people’s needs; they engaged well and appeared friendly and comfortable with them. We noted good interactions between people and staff. For example, we saw people approach staff members with queries and they appeared reassured by the responses from staff. However, our observations were limited at times during the inspection as most people chose to go out or remain in their bedrooms. There was some evidence of people making decisions about cooking, choosing the agenda for the residents’ meeting and having personal space when required. We looked at a selection of recent quality assurance questionnaires completed by people who used the service and their relatives, and the minutes for the residents’ meetings. The comments were positive about how staff treated people.

People were informed about how to access independent advocacy support, if they wished to. The minutes for a residents’ meeting demonstrated that people had been told about MIND, which provides an advocacy service within the London Borough of Hackney. The registered manager informed us people were encouraged to develop relationships with voluntary sector mental health organisations. For example, one person had been referred to MIND for a self-development course. Staff were knowledgeable about how to support people to access advocacy, apart from one staff member who told us they did not know and would refer the person to the deputy or registered manager. Leaflets were displayed on notice boards in regards to a range of local mental health services that people could access, managed by the statutory and voluntary sector.

Information about how to make a complaint was displayed on notice boards in communal areas. It informed people they could complain to the provider, or a health and social care professional involved in their care.

One person told us, “I am treated as an individual, with respect and dignity.” We found that people had personalised their own bedrooms if they wished to and practical actions were taken to promote people’s privacy and dignity, such as giving people keys and knocking on their doors to seek permission to enter.

We recommend the provider gives people written information about advocacy services.

Requires improvement

Is the service responsive?

Our findings

People using the service told us they felt well supported by a staff group that understood and met their needs. Staff were described as “approachable” and “helpful”. One relative said that staff provided their family member with the support they needed and another relative commented, “They care for him in a lovely way. We see this when we visit.”

We observed staff respond to people’s needs. For example, one person was anxious about their personal budgeting and was given reassurance by the deputy manager. Staff told us they knew people well and quickly recognised if there was any deterioration in a person’s mental health. In these circumstances staff members said they contacted the local community mental health team, to ensure people received appropriate care from medical and health care professionals. People were offered the opportunity to have one-to-one time with a member of staff who was assigned to provide individual support, known as a key worker. Records showed that these key worker meetings took place regularly.

Assessments of people’s needs were carried out when they moved into the service. These were used to identify the support people required and developed into plans of support. The assessments and support plans were comprehensive, individualised and written without jargon. The support plans clearly outlined where people needed support and contained instructions about how to provide the required support and covered a range of areas including personal care, managing behaviours that challenge the service, health care needs and achieving independent living skills. We were told by the registered manager that the philosophy of care was based on a holistic approach to care and Maslow's hierarchy of needs was in the forefront of this thinking. Maslow’s hierarchy of needs is a theory in psychology about meeting various needs of people, including esteem, safety and a sense of belonging. Information about this was displayed on the noticeboard for people and visitors, and a member of the care staff told us how they used it in their work with people. The registered manager described staff as resources for enabling people.

Staff told us they always attempted to involve people in planning and reviewing their care, and offered them a copy of their support plan. Although the support plans demonstrated that people were encouraged to participate in planning their support and care, there was not enough evidence of activities of daily living that residents were involved in and we did not see much documentation regarding people’s views of their recovery and their input in their programme. Staff told us that it was difficult to motivate some people due to reasons associated with their mental health.

People told us they were supported to engage in activities in the community. One person told us they were given an additional financial allowance to eat out every week at a restaurant which reflected their culture. A staff member told us they asked people to contribute ideas for a weekly outing. People often chose to explore different parts of Epping Forest, with a break for refreshments. Other activities included gym sessions, cinema trips and activities at a local mental health centre.

People told us they felt able to make a complaint about the service, if necessary. Relatives told us they had confidence in the registered manager to investigate any complaints in an open and professional way. The complaints policy and procedure were displayed on the notice board and people, and their representatives where applicable, were given a copy as part of their information guide when they moved in. The complaints log demonstrated the provider had responded to complaints in accordance with their policy and procedure.

The residents' meeting, which was held monthly, provided a forum for people to raise issues with the management team, which responded to any comments. We observed that people appeared confident to approach the staff to ask questions. The minutes for the residents’ meetings showed the agenda was set by people who used the service.

We recommend the provider seeks guidance from a reputable source to support people to identify and plan how they will engage more with daily activities, as part of their recovery.

Requires improvement

Is the service well-led?

Our findings

People and their relatives told us they were happy with how the service was managed. One person said they liked it and did not want to go back to the borough they used to live in. One relative told us, "I speak with the manager when I visit. He tells me what is going on and will spend time with me."

The registered manager had managed the service for over 10 years and was a qualified mental health nurse. We looked at copies of the reports relating to the most recent monitoring visits by the provider, which were brief, limited in scope and did not have sufficient depth to be effectively used as monitoring tool. For example, the monitoring visits' reports did not demonstrate checks relating to the quality of people's support plans.

The registered manager told us that he provided peer support to the registered managers at the provider's other local services and they supported him. There was no apparent structure in place for the registered manager to have professional and managerial support from the provider, which meant the service did not benefit from an effective system to monitor and evaluate the quality of care.

Staff told us that they were kept up to date about any changes at the service, through regular staff meetings. Care staff told us they had worked for the previous provider and transferred to the new provider last year. None of the care staff we spoke with during the inspection had so far met the new proprietor, in order to share views about the service and discuss possible future developments.

Satisfaction surveys were conducted to find out people's opinions about the quality of the service and the comments were positive. The feedback we received from community professionals was mixed. One professional informed us they had spoken with colleagues in their team about the service and commented, "The service is very good and we are pleased with the care provided to our clients. We have reviewed our clients and are happy with how they are being supported." Two professionals from another organisation told us about a number of concerns regarding the quality of the service, the suitability of the support given to people and the lack of co-operation demonstrated by particular staff.

There were a variety of daily, weekly and monthly audits which included the checking of support plans, risk assessments, fire safety, health and safety practices, and medicines management. We saw that recorded accidents and incidents were monitored, to make sure any triggers or trends were picked up. Support plans showed the service used this information to implement measures to reduce risks, wherever possible.

We recommend the provider demonstrates more rigorous monitoring of the service, and uses their findings to support the registered manager with improving the service.