Yad Voezer Limited

Yad Voezer 2

Inspection report

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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

Overall summary

This inspection took place on 7 July 2015 and was unannounced. At our previous inspection in July 2014 we found the provider was in breach of three regulations relating to care planning, the Mental Capacity Act 2005 and safe recruitment. During this inspection we found that improvements had been made in these areas and the provider was no longer in breach of these regulations.

The service is registered to provide care home accommodation for up to eight people. Six people were in residence, although one was in hospital at the time of the inspection. One bedroom is used by people for short breaks or respite care.

The home is for women only and all the staff and volunteers, with the exception of the manager,

are female. People who live in the home are members of the orthodox Jewish faith. Non-Jewish staff are supported to learn about the faith so that they can support people appropriately.

The registered manager of the provider's care home for men had applied to become the registered manager for this service too. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

We found the service was recruiting skilled and knowledgeable staff using safer recruitment procedures. They were well-informed about the Mental Capacity Act 2005 and about the needs and preferences of all the people they cared for. The provider gave staff access to good quality training to help them to meet people's individual needs. Staff had confidence in the management team and told us they were supportive and approachable.

There were sufficient staff to meet the needs of people and volunteers offered additional support, particularly in relation activities associated with people's faith.

A Kosher kitchen was kept and people enjoyed the food. The evening meal was delivered by a Jewish restaurant.

There was a 'family' atmosphere within the home, we observed positive relationships between the people who used the service and the staff and volunteers. People had access to a range of social, leisure and religious activities and participated in domestic tasks within the home.

A system of audits and checks ensured the management team identified most quality issues. There was evidence that they acted to rectify them and any learning points were discussed in well attended staff meetings.

Some improvements were needed in relation to the cleaning schedule, the temperature at which medicines were stored and the way risk assessments were completed. There was also a need to reduce the number of duplications and overlaps in record keeping. The provider had started work revising policies and procedures, but this work was not yet complete. We have made a recommendation about setting up a more detailed cleaning schedule to improve infection prevention and control.

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. The cleaning schedule required improvement to ensure nothing was overlooked and medicines needed to be stored at lower temperatures than that indicated on the provider's form.

Risk assessments were not always written in a logical manner.

Safety checks for gas safety, electrical installations, fire and legionella were up-to-date.

Appropriate checks were undertaken to establish the eligibility to work and suitability of new staff.

Is the service effective?

Good

The service was effective. New staff were required to have appropriate qualifications. All staff had benefitted from good quality training in relevant topics.

Staff were able to demonstrate they had a knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Appropriate procedures had been followed to ensure the service was acting lawfully in this area.

A Kosher kitchen was kept and people enjoyed the food provided.

Is the service caring?

Good

The service was caring. Staff, volunteers and people who used the service had a good rapport. People were treated with dignity and respect.

People who used the service chose to spend time together in the lounge and staff were primed to step in if anyone annoyed anyone else, as this could happen from time to time.

Is the service responsive?

Good

The service was responsive. Staff and volunteers were well informed about people's needs and preferences and they were also recorded in detailed care plans.

People had access to activities which reflected their interests and enabled them to participate in the customs and practice of their faith.

Complaints were followed up and care plans had been adjusted as a result.

Is the service well-led?

Requires Improvement

The service was not well-led in all areas. Although there was a plan to review all policies and procedures, this work had not been completed. In addition, duplications and overlaps in record keeping needed to be rectified to minimise the risk of errors occurring.

Summary of findings

However, the management team had the confidence of the staff and there were strong links with the local community. Checks and audits are picking up and addressing quality issues.

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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 7 July 2015 and was unannounced. It was carried out by a single inspector.

Before the inspection we reviewed the information we held on the service and we spoke with a local authority representative from the quality assurance and improvement team.

During the inspection visit we spoke with five people who used the service, two were able to answer our questions. We observed people during lunch and in the communal lounge. We interviewed four members of care staff, including the manager, and spoke briefly with two other support workers and a volunteer.

We looked at the care files for three people and two staff files, as well as a range of policies, procedures and records, such as medicines administration records, held by the provider.

Requires Improvement

Is the service safe?

Our findings

A person who used the service told us, "I feel safe here, there are no problems."

Staff had been trained in the safe administration of medicines. They carried out this task in pairs using a monitored dosage system supplied by a pharmacy. When we checked all the medicines administration records (MAR) we found the items and amount in stock corresponded with the records. Staff were using the correct codes on the MAR, for example, to indicate that a person did not receive their medicines because they were in hospital.

Medicines were stored safely and staff checked the temperature of each cupboard where they were stored. However, the temperature chart incorrectly stated that the safe maximum for storage was 30 degrees Centigrade, yet at least one of the medicines stored stated it should not be kept at over 25 degrees Centigrade. Keeping medicines at a higher than recommended temperature can impede their effectiveness and this was particularly important for the medicine in question as it was used to treat epileptic seizures.

Staff were able to tell us the steps they would take if they suspected any poor practice by their colleagues or abuse of people who used the service. They demonstrated a good grasp of safeguarding and whistle-blowing procedures and there was information on noticeboards to guide them, as well as an appropriate policy.

Accidents and incidents were recorded and there was evidence of follow up. There was good use of body mapping to record potential pressure areas and skin rashes, early identification and intervention had prevented any deterioration. A new accident log book had been introduced in June to make recording more systematic, but there had not been cause to use it yet.

There were risk assessments in place to prevent harm, but more thought needed to be given to the way they were completed. For example, one risk assessment described high blood pressure as an 'activity' and stated that 'increased road safety awareness' could reduce the risk. We could see the purpose of the risk assessment was to identify the steps to be taken to support the individual to reduce her high blood pressure, one of which was to increase the number of walks taken, but this was not clearly expressed.

When we spoke with staff members we found they were aware of the risks associated with individuals and their activities and we saw evidence that they had sought professional advice to help manage them. For example, one person with reduced mobility had difficulty getting in and out of vehicles, so an occupational therapist was asked to show her, as well as staff, how to do this safely with the help of a walking frame.

There was an up to date fire risk assessment and electrical installation, gas safety and legionella certificates. The fire log book showed fire drills had been carried out monthly and the fire alarm was tested weekly. On arrival the inspector was instructed about fire exits by the shift leader. We asked another member of staff about the home's emergency plan and they explained it to us without any hesitation which showed they were well informed about what to do if the home needed to be evacuated.

Orthodox Jewish customs ensured the premises received a deep-clean once a year in the lead up to the Pesach festival. A part-time cleaner was employed by the service and support workers completed cleaning tasks at other times. Personal protective equipment, such as disposable gloves and aprons, was available and other measures were in place to prevent the spread of infection, such as designated mops for bathrooms or the kitchen. Whilst the home looked and smelled clean, the cleaning schedule required further development to ensure each area and piece of equipment was cleaned at regular intervals, not just when it looked dirty. We found one or two small items which had been overlooked, but were in need of a clean.

The provider's recruitment procedure was safe. We looked at the recruitment process followed during the two most recent staff appointments and saw that appropriate checks had been made to ensure people were eligible to work in the UK, were of good character and had suitable skills and knowledge.

People who used the service benefited from staffing levels which met their needs. The rota took account of the two to one support needed by some people for some activities. We saw evidence in the staff rota that additional staff members were brought in to accompany people to appointments when required. Staff told us bank staff were available to cover any absence or additional duties and they did not have to work beyond their contracted hours unless they wished to. The rota confirmed this.

Requires Improvement

Is the service safe?

Paid staff were supplemented by a number of committed volunteers who supported people to follow their faith and with leisure activities. Staff members told us how important this support was and how much they and the people who used the service appreciated it.

We recommend that the provider seeks guidance from a reputable source to set up a cleaning schedule appropriate for a care home in order to prevent and control infection.

Good

Is the service effective?

Our findings

The longer-standing members of staff we spoke with told us staff training had "really improved."

The provider had recently raised the threshold for care staff appointed to the organisation. They were only recruiting those who had achieved National Vocational Qualification (NVQ) 3 in health and social care or equivalent qualifications. We found the staff we spoke with to be well informed about the people they cared for and the provider's policies and procedures.

We saw induction checklists had been completed for new staff. They indicated that they had been familiarised with the expectations of the provider, with the people who used the service and with safety in the home. Thereafter staff attended mandatory training and also had the opportunity to attend a wide range of other short courses relevant to the care of people who used the service. Training records, attendance sheets and course certificates confirmed this. A new, but experienced, member of staff was full of praise for the manual handling training, comparing it favourably to her previous training on this topic. She told us she got the opportunity to experience the techniques used from the perspective of a person who used the service and said she now fully appreciated how scary it could be to be transferred using a hoist.

Records reviewed demonstrated staff had regular supervision sessions with their line manager and an annual appraisal had been introduced.

We received a full explanation about the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) from a support worker. It was clear she had a good understanding of this area of their work; she understood assessments of capacity were decision-specific and knew that someone who had been assessed not to have capacity to, for example, manage their finances, should still be offered simple choices about other areas of their life. Other staff we spoke with also broadly understood their responsibilities in this area.

At the time of the inspection DoLS had been granted in respect of one person and the provider had requested assessments of capacity for others from local health and social care professionals.

Kosher food was provided and the kitchen was arranged to facilitate this. Support workers prepared breakfast, lunch and snacks and the evening meal was delivered by a local restaurant. People's food preferences were well-known to staff and documented. A pureed diet was provided for one person. People who used the service were consulted about the menu at regular intervals. During the inspection we observed that everyone present really enjoyed their lunch, no one left a morsel of food on their plate and some had second helpings.

Records showed that people had good access to healthcare and staff were usually able to identify when individuals were becoming unwell, because they knew what was unusual for them. A particular strength of the service was its commitment to supporting people when they were hospital in-patients. This ensured they could maintain their religious practices and it also provided them with emotional support.

The premises had ramps to the ground floor and one wheelchair accessible bedroom and shower room. Communal rooms were also on the ground floor. There was a ramp to the large rear garden. Other bedrooms and bathrooms required people to use stairs. The décor was in need of refreshment in some areas, but we were informed by the provider and a local authority representative that this was planned as soon as work had finished in the provider's other care home. A shed used for storage was also going to be replaced. Staff told us there was a quick response when urgent repairs were needed and we saw this was the case from the repairs book.

Good

Is the service caring?

Our findings

One person who used the service told us the staff were “nice”. Another person said, “I like everyone” and “Nobody is mean.”

We observed numerous examples of positive relationships between the staff on duty and people who used the service. Warmth and appropriate humour were much in evidence. When staff spoke about the people they supported they were respectful of them and their faith and clearly enjoyed working with them.

There was a ‘family atmosphere’ within the home, even though those that lived there had a wide range of needs and sometimes annoyed one another. This was because staff and volunteers were alert to potential friction and stepped in to avert it. We saw people actively chose to spend time in each other’s company.

The majority of staff were not Jewish, but they told us they had received basic information as part of their induction and were continuing to learn. They said Jewish staff members and volunteers were extremely helpful in this regard. A person who used the service told us about some aspects of their faith, such as what they wore. There were plenty of opportunities for them to practice their religion, such as daily prayers. Care files contained guidance to staff about Jewish practice in the event of a death, including who needed to be informed.

When staff spoke with people and when they spoke about them to us, we saw they were mindful of confidentiality. Protecting people’s dignity and privacy was observed to be embedded within staff practice. They were discreet when needed, such as when prompting people to go to the toilet.

Good

Is the service responsive?

Our findings

One person said, “I like the singing we do” and “I like colouring in.” Another said they liked helping with the cooking. One other person demonstrated their enjoyment of the warm weather by lying out in the garden.

People were given the opportunity to do things they wanted to do because staff and volunteers were well-informed about the needs and preferences of people who used the service. One person told us about the things which were important to her and later a volunteer listed exactly the same things when speaking about her. They were also recorded in her care file.

People’s needs were assessed by the local authority prior to admission to the home. We saw evidence of referrals for re-assessment being made to health and social care professionals when people’s needs changed.

Care plans were detailed and gave guidance to staff about how best to support people. They had been recently reviewed, the manager explained how they tried to involve people in developing their care plans, but acknowledged there was more work to do in this area.

Each person had an activities time-table which reflected their interests. Most people attended activities in the local community, but there were also in-house activities. There were lots of board games available which we saw people playing. Volunteers came in to lead some activities within the home, such as singing Jewish songs or to host the Shabbas meal. On the day of the inspection, one person who expressed very specific ideas about the sort of shoes they wanted was supported by a volunteer to find and buy shoes that they were happy with.

We observed that, supported by staff, people who used the service participated in various aspects of the daily life of the home, such as cooking, shopping, changing their sheets and tidying their bedrooms. Whilst staff had to work hard to encourage some people to join in these activities, others told us they loved to carry out these tasks.

Complaints were logged and follow up actions were recorded. There was one outstanding complaint which was being dealt with by the provider’s head office. There was evidence of learning from complaints, for example, one person was now supported in a particular way when outside in the community in order to manage a specific risk.

We observed the manager liaising with various professionals to try to ensure a person being discharged from hospital with complex health needs had a smooth transition back to the care home. From the tone and content of the conversations and emails, the manager had established positive working relationships with both the hospital discharge team and social services.

Requires Improvement

Is the service well-led?

Our findings

We saw evidence of a positive culture within the home. A member of staff had owned up when they forgot to give someone their medicine. The provider responded by insisting on re-training in this area rather than taking disciplinary action. This was in recognition of the staff member's honesty. The registered manager said they wanted to encourage staff to admit to and learn from mistakes as this was safer for people who used the service.

The staff we spoke with described good team working. They said that when petty annoyances arose they were dealt with. One staff member said, "We sort it out like adults."

Staff spoke highly of the provider, the manager and his deputy. They told us the manager had brought in many changes since he took over and they were "all for the better." They described a supportive working environment and said management was approachable. The manager worked across two care homes. In this home he was supported by a female deputy manager in recognition of this being a home for women.

A new service manager had recently been employed by the provider and we were told one of their tasks would be to overhaul the provider's policies and procedures. Whilst there were appropriate policies and procedures in place we saw some of them would benefit from updating and cross-referencing. The provider had started to subscribe to a company which would assist them in this task.

Staff were usually good at keeping records and the weekly checks and monthly audits carried out within the home had identified where problems were occurring. There was evidence of follow up too, for example, we saw a new behaviour monitoring form was being piloted because staff had difficulty filling out the old one.

However, duplications and overlaps needed to be rectified to minimise the risk of error. For example, whilst the medicines administration record (MAR) charts were up to date and accurate, several other forms within the care files required medicines information to be entered, but it was not updated when individuals' medicines changed. One such document was the hospital passport which could result in the wrong information being given to medical staff. An improved system for archiving old information would also reduce the risk of staff using the wrong version of a document. For example, two important digits had changed in one person's epilepsy care plan, otherwise it was identical to the previous year's care plan. Anyone checking how long they should wait before summoning help in an emergency could easily look at the out of date plan which indicated a longer wait was appropriate.

Records in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were not as explicit as they could be. For example, the working care files did not always show whether DoLS had been granted or was in the process of being applied for. This would help staff to know exactly what restrictions were in place for whom.

The provider had embedded an open culture by establishing good communication between colleagues. Minutes of the well-attended staff meetings showed the provider had been open about changes within the organisation. All the minutes since the last inspection were of a high standard, making them easy to read for anyone who missed the meeting. We saw evidence of learning from local authority commissioners' visits and from the CQC inspection of the provider's other care home. Lots of other relevant issues were also covered in staff meetings. Staff could not have prepared for an unannounced inspection, but we found they were all in possession of very similar information, which confirmed to us that communication within the home was good.

The local community was described as "extremely supportive" of the home by the staff and they told us they themselves were respected by the community for the work they did. The manager said he could rely on community members to inform him if they had any concerns about the standard of care provided.

We looked at some of the financial records relating to expenditure by and on behalf of individuals who used the service and saw that appropriate authorisations were in place. The local authority had previously picked up on an error which had resulted in people being charged for an activity which was covered by their contract and the provider was in the process of arranging reimbursement. The registered manager had recently identified that some staff were not entering specific enough descriptions of purchases made and had used a team meeting to remind them of the need to provide more details. This

Requires Improvement

Is the service well-led?

demonstrated management checked individuals' financial records for which the service was responsible and, if the provider's procedures were not followed correctly, this was now picked up