Care Quality Commission

Kisharon

Kisharon Supported Living

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was took place on 10 July 2014 and was announced, which meant the provider was informed two working days beforehand to ensure that key members of the management team would be available.

Kisharon Supported Living provides a supported living service to people in their own homes. Its services are primarily for adults with a learning disability. At the time of our visit, the service was providing personal care to three people in their own supported living scheme homes.

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

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At our previous inspection in October 2013, the provider was found to be meeting the required standards in the areas of respecting and involving people, planning and delivering care, recruitment, and the assessment and monitoring of service quality. However, the provider was not meeting regulations in relation to the management of medicines and supporting workers. At this inspection, we found that they had addressed our concerns, and we found no breaches of relevant regulations.

Feedback about the service from people, their representatives, and health and social care professionals was mostly positive. In particular, all three relatives and representatives felt they could recommend the service to others.

Staff knew people's support needs and we observed positive interactions between people and staff. We saw staff being caring and respectful to people, and communicated effectively with them. People were supported to express their views, and were listened to. Staff placed value in people using the service, and were supported by a management team that promoted a positive, inclusive and empowering culture.

Systems were in place to help protect people from harm or abuse. Recruitment processes were robust, and there were ongoing checks of the suitability of established staff. The service had enough capable staff to support people and keep them safe. The service responded to people's individual needs and preferences, and understood that by listening to people and aiming to meet their individual needs, the risk of abuse was reduced.

People were supported to maintain good health and address health concerns. They were supported to maintain a balanced and culturally-appropriate diet of their choosing, and so were protected against the risks of malnutrition. People were supported to participate in a range of varied and meaningful activities including employment and college courses.

We were assured that the provider was taking steps to ensure that the requirements of the Mental Capacity Act 2005 and associated codes of practice were being addressed.

Staff were guided to provide effective services to people. They were trained and supervised in support of this, which helped protect people against the risks of inappropriate care. There were systems in place to monitor the quality of the service. Where issues were identified, actions were taken to make improvements, which helped assure us that the provider aimed to deliver high quality care and support to people.

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?

Good

The service was safe. Recruitment process were robust, and there were ongoing checks of the suitability of established staff. The provider had procedures in place to safeguard people using the service. Staff knew how to recognise and respond to signs of abuse.

The service had enough capable staff to support people and keep them safe. The provider managed risks to people on an individual basis, and there were arrangements in place for dealing with foreseeable emergencies. People received support to manage their medicines safely.

We were assured that the provider was taking steps to ensure that the requirements of the Mental Capacity Act 2005 and associated codes of practice were being addressed.

Is the service effective?

Good

The service was effective. People were supported to maintain good health and address health concerns. They were supported to maintain a balanced and culturally-appropriate diet of their choosing, and so were protected against the risks of malnutrition.

Staff were guided to provide effective services to people. They were trained and supervised in support of this, which helped protect people against the risks of inappropriate care.

Is the service caring?

Good

The service was caring. We observed positive and respectful interactions between staff and people using the service, and we received positive feedback about this. Staff knew how to communicate with each person according to the person's abilities. The service valued people being supported to express their views.

We found that consistent staffing was organised, so that people were supported by a small number of staff who understood their needs.

Is the service responsive?

Good

The service was responsive. The service planned and delivered care and support to people that aimed to respond to their individual needs. Improvements were being made to the care planning processes.

The service supported people to participate in a range of varied and meaningful activities including employment and college courses.

Concerns and complaints were responded to appropriately and action taken to improve the service as a result.

Is the service well-led?

Good

The service was well-led. Staff placed value in people using the service, and were supported by a management team that promoted a positive, inclusive and empowering culture.

There were systems in place to monitor the quality of the service. Where issues were identified, actions were taken to make improvements.

Care Quality Commission

Kisharon Supported Living

Detailed findings

Background to this inspection

This inspection was carried out by one CQC inspector on 10 July 2014. Before the inspection visit, we reviewed information we held on the service such as notifications from the provider about events that occurred in the service and two questionnaire results we received from a staff member and a healthcare professional. We also gained the views of the local authority's commissioning team. The provider completed a Provider Information Return (PIR) as requested by us. 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. This information helped us plan the inspection visit.

We spoke with three people using the service during our inspection visit. We had communication difficulties with some people, and we were therefore unable to have many of our questions, about the care and support they received, answered verbally. We spent time observing care and support provided to two people in the communal living area of their home. This included using the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection visit, we spoke with three support staff, the registered manager, and six other members of staff involved in assisting to provide services to people. We looked at two people's support records including care plans and care delivery records, one staff file, and other records relating to the management of the service, such as staff duty rosters, training records, complaints records and meeting minutes.

After the inspection visit, we spoke with three relatives and representatives of people, to gain their views of the service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People we spoke with, their relatives and representatives, and healthcare professionals told us the service was safe. Relatives' and representatives' comments included, "They're very aware of safety, it's paramount" and "It's safe because staff have had training and as long as staff ratios continue."

One relative told us that if a care worker was sick, the service found a suitable replacement. A person using the service confirmed that there were enough competent staff, and another described the staff as "nice." Our checks of staffing records and other information assured us that the service had enough capable staff to support people. However, we were also shown that people's needs were kept under review, and where increased needs were identified, the service highlighted this to the funding authority in support of gaining additional staffing hours.

A relative told us that they believed staff to be carefully interviewed. We met with human resources staff who demonstrated competency at safe recruitment practices and ongoing fitness-to-work checks of established staff. They had attended a 'safer recruitment' training course hosted by the local authority. We were shown systems of monitoring that appropriate checks of staff, such as criminal records checks and valid entitlement to work in the UK, were being used effectively before new staff started work and when established staff required further checks. Records demonstrated that appropriate action had been taken where these checks raised concerns, for example, in assessing risk and taking precautionary action when a check raised safety concerns, and if necessary, preventing the staff member from working with people using the service. We noted that in support of these decisions, the provider had access to legal advice that specialised in care employment matters.

We looked at the personnel files for one of the few new care staff members since our last inspection. The recruitment checks included proof of identity, written references from previous care employers, and written evidence of an interview by two members of the management team. The interview included a number of questions pertinent to the safety and welfare of people using the service, such as for safeguarding from abuse, dignity in care, anti-discriminatory practices, and the development of people's independence. We established that the staff member had not started working with people using the service until all appropriate recruitment checks had taken place, and they had received a contract, handbook, and key policies on the safety and welfare of people. We were assured that the provider followed appropriate recruitment processes to ensure that people using the service were protected from staff unsuitable to work in social care.

The provider had a safeguarding policy in place. We were shown records of review of the policy, to keep it up-to-date with relevant national guidance, and of it then being sent to all staff for their awareness. Checklists for the induction of new staff included discussion of the policy on the first day of working for the service, and we were shown how recruitment adverts for new staff demonstrated the provider's commitment to safeguarding people.

Staff we spoke with said they had received recent training on safeguarding. There were records of this, both by the provider and through the local authority. Staff had awareness of what could be seen as abuse and understood that by listening to people and meeting their individual needs, the risk of abuse was reduced. They were aware of actions to take when responding to allegations or incidents of abuse. This included keeping people safe and reporting allegations to a manager. Staff explained how a manager was contactable at any time of day and night to provide support where needed.

We saw clear records of where staff helped people to manage their finances, for example, in buying food for them. The manager informed us of regular audits of these processes, with information passed onto involved relatives where appropriate. We received positive feedback from an independent health and social care professional about the robustness of the service's financial processes. This assured that the service helped to protect people from the risks of financial abuse.

The manager kept us informed of any matters that were considered under the provider's safeguarding procedures. They had contacted the local authority for advice on whether specific incidents needed to be considered under local safeguarding processes. This helped assure us that people using service were protected by the provider's safeguarding systems and external stakeholders were kept appropriately involved.

The service had a policy in place on the application of the Mental Capacity Act 2005 (MCA). It recognised many

Good

Is the service safe?

aspects of the associated guidance, however, it did not make reference to the recent Supreme Court judgement that affected expectations around how the MCA should be implemented. It also placed too much emphasis on delegating towards community healthcare professionals and so did not recognise the responsibilities of the provider and its staff in meeting the guidance of the MCA. However, we did not come across any cases during the inspection process that indicated a risk of people using the service being unlawfully deprived of their liberty. For example, staff told us that locks had been taken off the kitchen door in one scheme, which helped to demonstrate that restrictive practices had been reviewed at that scheme in line with MCA guidance. We also saw that when one person indicated they wanted to go out, staff safely supported them to do so.

Staff we spoke with understood the importance of obtaining the consent of the person before any care or support took place. We observed staff asking people's permission before any support was provided, and listening if people refused requests. The manager told us that listening to people was a key factor in working to reduce instances of people's behaviour challenging the service.

Staff confirmed they had undertaken training on the MCA. They could demonstrate awareness of how the MCA was applied in their support of people. They were aware of respecting people's choices, but where they had concerns about a choice made by someone, they explained risks and suggested alternatives. They knew that the service must always act in the best interests of the person when they lacked capacity. The management team gave us an example of how they had supported someone and their family when a best interests treatment decision had been made by health and social care professionals. We were assured that the provider was taking steps to ensure that the requirements of the MCA and associated codes of practice were being addressed.

People's care files included risk assessments covering areas such as night care, health conditions, and bathing. They set out the actions that needed to be taken and had been reviewed and updated regularly and when new risks were identified. A relative told us that the staff worked within agreed guidelines to help keep people safe.

In one scheme, an emergency bag was in place for easy access should someone need to attend hospital at short notice. First aid boxes were in place at each scheme, and records showed that all staff had undertaken emergency first aid training. There were records of regular health and safety checks in each scheme, and the service had a designated health and safety manager in place to oversee safety within the provider's services. A business continuity plan was in place and kept under review. This helped assure us that the provider managed risks to individuals as part of the service provided to them, and that arrangements were in place for dealing with foreseeable emergencies.

The provider had made arrangements for the safe storage of medicines in people's homes. In one scheme, we were shown how liaison with the local pharmacist had enabled the use of monitored-dosage systems which helped reduce the risk of error when staff supported people with medicines.

Staff told us, and training records confirmed, that staff had training on the safe handling of medicines. We looked at two people's medicine administration records (MAR) for the current and previous months. Appropriate records of medicines coming into a scheme, and being returned to the pharmacist, were in place. Staff checked prescription orders and made sure that these corresponded with the medicines that each person received. Records showed that where a mistake had been made, the local pharmacist was contacted to correct matters, which meant staff took appropriate action to help people to receive their medicines as prescribed.

Records showed that the management team were auditing medicines procedures on a regular basis. Stock-levels were checked each time a new MAR was started. We checked records of some medicines, and found the remaining numbers of tablets matched administration records, which helped to assure that people had been supported to receive their medicines as prescribed.

Staff had signed the MAR appropriately in most cases, however, one person's MAR had not been signed for the last two days. It was recorded that the person sometimes refused to take their medicine. We checked stock levels against recent records and found no discrepancy between these, and other records showed that staff had been supporting the person across these days. This indicated that it was likely that the person had refused their medicines on the last two days but that the required records of this had not been made.

Good

Is the service effective?

Our findings

People expressed satisfaction with the meals provided. One person told us staff supported them to have enough to eat, another said, “Good food.” A relative told us of how the service was providing support to their relative with choosing healthier meal options and developing their cooking skills. Staff spoke of how they encouraged people to make healthier eating choices, and for example, supported people to prepare and cook meals.

People's care plans recorded their cultural dietary needs. Staff said they supported people to plan their menu for the week. We saw kosher meals served to people in one scheme. It was clear that fresh foods were used in support of people’s nutrition. We saw that people were provided with sufficient time and support to eat. Staff showed us practical systems by which they supported people to keep food and kitchen equipment in line with cultural practices, and that the service’s cultural advisor audited these practices. We noted that people’s weight was monitored where they agreed to this. We were assured that people were supported to maintain a balanced and culturally-appropriate diet of their choosing, and so were protected against the risks of malnutrition.

One person told us that staff supported them to appointments, such as with their GP, when it was required. Records showed that where necessary, appropriate professionals such as doctors, dentists and psychiatrists had been consulted for advice about people’s health needs. We checked the health action plan and Hospital Passport in place for one person. These gave information on effective communication with the person, their preferences and how to work well with them, specific health needs and information, cultural considerations, and relevant contact details.

The feedback we received from health and social care professionals indicated that the service was effective at meeting people’s needs. A relative told us of how the service had liaised with a community healthcare professional which resulted in a list of recommendations that the service was working through in support of addressing their relative’s particular healthcare needs. One person’s records demonstrated how they had been positively supported with their dental care and healthy eating. A staff member explained the support they were providing someone with in respect of a new healthcare need. This included personal care support and liaison with healthcare professionals. We were assured that the service supported people to maintain good health and address health concerns.

Staff told us they received regular training to deliver care and support safely and meet people’s needs. This included both online and face-to-face courses. Records indicated that some staff had a National Vocational Qualification (NVQ) in care. The manager told us that a training provider had been secured for more staff to undertake the new version of this qualification. Staff training records showed that support staff had completed training in areas such as emergency first aid, fire safety and food hygiene. We saw that the provider recorded the training courses staff had attended and alerted staff of refresher training courses when required. There were records of ongoing monitoring and encouragement of staff to complete online training.

Staff told us that they felt supported to perform their role, that managers in the organisation were effective, and that they received regular supervision meetings. There were records of supervision that showed staff received regular formal support on a three-monthly basis, and that their performance was monitored with additional supervision meetings if necessary. There were records of staff receiving a revised handbook earlier in the year, which clarified roles and responsibilities. This helped to assure us that staff were guided and supported to provide effective services to people.

Good

Is the service caring?

Our findings

People's relatives and representatives told us they felt staff were caring and kind to people. Comments included, "They're genuinely caring and considerate." One relative also praised the management team for their ability to recruit caring staff.

We observed staff interacting with people in a friendly and warm manner and asking them about their support needs and what they wanted to do. The way staff interacted with people had a positive effect on their well-being. For example, one person was reassured by the presence and calm interactions of a staff member who was supporting them, and who listened to them when they requested to go out to a specific venue.

All the relatives and representatives of people we contacted, and healthcare professionals, informed us that people's privacy and dignity was maintained. Comments included, "They're respectful and they get [my relative] to decide things where possible." Staff we spoke with were conscious of treating people respectfully at all times, and we saw that this was the case during our inspection visit. For example, people had been provided with support, where needed, for their appearance. Themes of dignity, respect, and independence were evident throughout care plans and in our conversations with staff and the management team. They spoke of people's potential, which indicated the value they placed on people.

One relative told us that staff were improving on noticing non-verbal cues from their relative. We saw staff involve people in making choices, and explain the support they wished to give before providing it. Staff listened and responded to people using the service, and we saw people using assistive technologies such as specific IPad software to communicate effectively. Records indicated that staff had had recent training on communicating with people. We were assured that staff knew how to communicate with each person according to the person's abilities.

A health and social care professional fed-back positively about how the service advocated on behalf of people using it. We noted that one of the people using the service had an independent advocate in place. We saw reference to advocacy services within the provider's newsletters and on their website. Relatives told us the service kept them informed, and listened to their views on behalf of their relative. This helped assure us that the service valued people being supported to express their views.

Relatives and representatives fed-back about there being consistent staffing, for example, "It's mainly the same care workers." We noted that most of the small staff team at one scheme had been working with people living there at the time of our last inspection eight months ago. One staff member told us that the person they worked with "loves consistency" and so the person received support mainly from two specific staff members, which records confirmed. This helped assure us that consistent staffing was organised, so that people were supported by a small number of staff who understood their needs.

Good

Is the service responsive?

Our findings

Relatives told us that the service was responsive to people's individual needs. Comments included, "Staff understand [my relative's] needs, and they are coached by the bosses" and "They follow a set routine and they're very attentive…which helps alleviate stress for [my relative]." Staff we spoke with understood people's individual care needs and the support they were to provide. There was recent evidence that people were involved in their support planning through meetings with their key-worker. We saw other records indicating that people and their families were listened to in respect of their individual care and support, which relatives we spoke with confirmed. Whilst care plans did not directly indicate how people and their representatives were involved in agreeing the care and support to be provided, other evidence assured us that was occurring in practice.

We looked at two people's care records. These were comprehensive and showed the person's individual abilities and needs across a wide range of support areas that included communication, personal care, nutrition, and health matters. They contained clear information on the person's likes and dislikes. Plans had been reviewed and updated. However, we informed the management team that the plans did not clearly identify the support that staff were to provide. We were shown detailed daily task sheets that staff were starting to use to help them support two people. We were told a similar system was being set up for the third person. This followed a review of care planning and recording systems that was undertaken by a specialist service. This helped assure us that the service planned and delivered care and support to people that aimed to respond to their individual needs.

We saw people being supported to develop independent living skills, for example, in setting the table for dinner and in answering the front door safely. Records and feedback for one person showed that they had developed their hand-washing skills. Work was starting to take place to enable another person to develop cooking skills. This helped assure us that the service encouraged people to develop skills. However, for two people we checked on, care plans did not have clear skills development goals, and reviews of the goals were vague and lacked clear evidence of progress. We discussed this with the management team in support of encouraging the service to improve.

A relative told us that their relative was being supported with many activities in the community. They gave examples of how this helped the person to have a positive community presence. The provider had a designated employee supporting people for this purpose. One person told us that this employee had visited them recently, to help them acquire new employment opportunities which the person was keen on. They spoke positively about recent employment they had had through this process. This helped assure us that the service supported people to participate in a range of varied and meaningful activities including employment and college courses.

Relatives told us the service kept in good communication with them. If they had any concerns, they found the service to respond to them well and in good time. For example, "They usually respond within 24 hours even if it's something minor."

The provider's complaints record showed that concerns and complaints were responded to appropriately and action taken to improve the service as a result. For example, discussion had taken place at a staff meeting about safely addressing some dissatisfaction expressed by someone using the service. Records and feedback indicated that this had been effective, and we saw that a minor alteration to practical living arrangements had also been made in support of the concern.

Good

Is the service well-led?

Our findings

Relatives told us the service was well-led. One relative said, “They don’t say ‘we know better’ ” which the relative appreciated. A healthcare professional gave us positive feedback about how the service sought their advice where appropriate and took action as a result. Their feedback indicated that the service worked in co-operation with them. We received no specific feedback from people about how well-led the service is. However, when we visited people, it was clear that they knew members of the management team and had positive relationships with them.

Staff said they were proud to work at the service and that they valued the empowerment of people using the service. They told us they felt supported in their roles, and that managers were approachable and worked with them to resolve any concerns they had. We saw records of communication from the management team to staff that valued staff contributions, for example, for helping someone to attend a health appointment that involved changes to people’s routines. Staff meeting minutes demonstrated that whilst there was a culture of support for staff, clear performance expectations were set when the provider identified shortfalls in how the service was ensuring the safety and welfare of people using the service. The meetings also recorded staff views, which demonstrated their high expectations for the care and support of people.

The manager told us of monitoring staff members’ abilities to work effectively with each person using the service. Where good relationships were not established or people using the service raised concerns, staff members were moved. We received feedback from people and their representatives which confirmed that this occurred to positive effect. We also saw records and received feedback from staff and the management team explaining how staff working hours for one person had been altered to better meet the person’s needs. This helped assure us that the service aimed to deliver high quality care.

We saw many newspaper articles on how the provider engaged with the local community and helped to positively portray and involve people using the services at community events. The provider’s website provided a range of easy-read documents such as the provider’s annual review and current newsletters. This helped assure us of an inclusive and empowering culture at the service.

The manager told us people using the service, their representatives, and staff had recently been sent questionnaires asking what they thought of the service. We saw some responses, including easy-read versions that had been used for some people to help establish their views. The service was using the feedback to improve the quality of care.

The provider had systems in place to monitor the quality of the service provided to people. We saw weekly updates from managers within specific schemes that were sent to the senior management team. These included areas such as service incidents, staff development, the views of people using the service and their representatives, and updates on how individual people were being supported by the service. There was evidence of action being taken where service shortfalls were identified, for example, on improving how staff communicated with someone in line with professional guidance provided. This also helped to demonstrate that the action plan arising from the service’s recent annual questionnaires to people and their representatives was being followed.

We saw that weekly health and safety checks took place within the schemes. The manager visited and monitored schemes weekly. Records of this showed audit of aspects of the service provided to people, including safety checks, attention to individual health and care needs, and staff support. Staff told us that members of the management team checked on the practical services being provided to people from time to time, and that they did not know of these visits in advance. This helped assure us of good management of the service in support of delivering high quality care.

We were shown an extensive action plan on reducing risk to one person following a service-delivery incident. We also saw records of an unrelated staff meeting called at short notice in response to concerns raised by staff about an aspect of the service delivery in one scheme. Actions were agreed from the meeting, and were being monitored by the management team to ensure that improvements were made to the service. This helped assure us that the provider monitored service delivery and took action in response to identified concerns.