Jewish Care

Rubens House

Inspection report

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Date of inspection visit: 27 January 2016
Date of publication: 22/03/2016

Ratings

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

Overall summary

This inspection took place on 27 January 2016 and was unannounced. Rubens House is a care home that is registered to provide accommodation and personal care for up to 48 people. The home is run by Jewish Care, a voluntary organisation. There were 39 people living in the home at the time of this inspection.

The home did not have a registered manager as the previous registered manager was no longer working at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was an interim manager in place who advised that they would cover the home until a new registered manager was appointed.

Due to changes in management, and a large number of staff vacancies at the home, staff had not receive sufficiently regular supervision meetings in recent months to support them in their role. Agency staff were not provided with clear recorded induction and orientation information before working with people. People who were unable to consent to care did not have best interest decisions recorded for them, and deprivation of liberty safeguards were not in place for all people who required this.

Summary of findings

Improvements were being put in place, however the majority of care records inspected for people living at the home did not include sufficient current and personalised information to ensure that their changing needs were addressed promptly.

The home was clean and there was a refurbishment programme in place. People told us that their care needs were met, and they were provided with their medicines safely. Action had been taken to reduce the number of agency staff working at the home with ongoing recruitment of permanent staff. Safe systems were in place for recruiting staff.

Staff training needs were assessed, with systems in place to make sure they had training in mandatory and other relevant areas. Staff showed a good knowledge of people's life histories and preferences regarding their care and support needs. They were clear about the procedures for reporting abuse and felt that management listened to their views.

People were provided with a choice of food at all meal times, and were supported to eat when this was needed. They spoke positively about the food provision in the home. They were also satisfied with the range of activities available to them.

People's health needs were met, and they were supported to consult with health and social care professionals as needed without delay. They had the opportunity to be involved in decisions about their care and how they spent their time at the home. They and their relatives attended meetings or spoke directly to a manager to raise any issues of concern.

The provider had systems for monitoring the quality of the service and engaged with people and their relatives to address any concerns. When people made complaints they were addressed appropriately.

At this inspection there were three breaches of regulations, in relation to staff supervision, the Mental Capacity Act 2005, and monitoring of changes in care recorded. You can see what action we told the provider to take at the back of the full version of the report.

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. Staff knew the correct procedures to follow if they suspected that abuse had occurred. There were assessments in place to minimise identified risks to people.

Safe recruitment procedures were in place, and the home was in the process of recruiting staff to fill vacancies.

People received their medicines safely. The home was clean and hygienic.

Is the service effective?

Requires improvement

The service was not always effective. A training programme was in place, but staff had not been receiving regular supervision sessions in recent months, and there was no recorded agency staff induction or orientation.

Staff understood people's right to make choices about their care, and the requirements of the Mental Capacity Act 2005, however records did not reflect best interest decisions made for people unable to consent, and further Deprivation of Liberty Safeguards were required.

People received a varied choice of meals and staff supported them to meet their nutritional needs.

People's health care needs were monitored. People were referred to health care professionals as required.

Is the service caring?

Good

The service was caring. Staff were caring and knowledgeable about the people they supported, and understood their preferences and life histories.

There were opportunities for consultation with people and their representatives about their care and support.

Is the service responsive?

Requires improvement

The service was not always responsive. The home was updating care plans to a more personalised format. However most care records were not yet sufficiently detailed and precise, to ensure that people's needs were met fully and responsively.

People using the service and their relatives were encouraged to give feedback on the service and use the complaints system.

A range of activities were available for people including occasional trips out of the home.

Summary of findings

Is the service well-led?

The service was well-led. The provider had systems for assessing and monitoring the quality of the service, and had brought about significant improvements. Management were aware of improvements that were still needed. People found the management team to be positive, approachable and supportive.

Good

Rubens House

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.

At the previous inspection of the home in September 2014 we found that the provider was not meeting one of the regulations inspected relating to sufficient staffing to meet people's needs.

Prior to the current inspection we reviewed the information we had about the service. This included an action plan sent to us by the provider to address the above breach and any notifications of significant incidents affecting people living at the service.

This inspection took place on 27 January 2016 and was unannounced. The inspection was carried out by two inspectors, a specialist advisor who was a nurse with professional experience of working with older people, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of the inspection there were 39 people living at Rubens House. We spoke with 12 people living at the home, and six relatives or friends who were visiting people there. We looked at the care plans, risk assessments, and daily records relating to 14 people, and medication administration records for 18 people.

We observed care in communal areas across the home, including medicines administration, mealtimes, and a residents meeting. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being.

We spoke with five care staff (including two team leaders), the social support worker (activities coordinator), the chef, the head of hospitality, an occupational therapist for the service, the interim manager, deputy manager and service manager. We also spoke with two visiting health and social care professionals during the visit, and one social care professional following the visit.

We looked at seven staff files for recruitment, training and supervision records, the last month of staff duty rotas, accident and incident records, selected policies and procedures, and records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us that they or their relatives felt safe within the home. One person told us, "Yes I feel safe here. I get support with washing and dressing .. and staff are good." Another person said, "Oh yes I feel safe." A relative told us, "Mum's safe, cared for and I can sleep at night knowing that."

However another relative said, "I know them all but I think they could do with more carers. When there are unexpected absences they do struggle." Another relative told us, "They are very stretched at times and need to recruit more staff."

At the previous inspection on 16 and 17 September 2014, we found that the service did not have sufficient staff at all times in order to safeguard people's health, safety and welfare. Concerns related particularly to the evening/night time following a serious incident which took place at the home. The provider sent us an action plan detailing actions taken after the inspection including providing an additional staff member in the evening for a trial period.

During the current inspection there were nine vacancies in the home. Staff mainly worked long days (early and late shifts consecutively). During the day there were ten care staff on duty. We were told that this would increase to 12 staff when the home was full. At night there were five staff including a team leader on duty. The team leader was responsible for medicines administration and also assisted with personal care. An increase of one extra night staff had been piloted following the last inspection, but this was not found to have a significant impact on the safety of people living at the home. Prior to the current inspection there had been significant staffing problems leading to the use of approximately fifty per cent agency care staff at times. The management acknowledged that this was a significant issue which was being addressed through active recruitment, and management support.

The service manager had produced a service improvement plan from August 2015 to March 2016 with actions put in place to improve staff management on each shift. This took into consideration the most pressured times at the service, which impacted on people's experience of care in the home. For example staff break times were changed so that these did not coincide with meal times at the home, when significant staff support was needed. Recruitment was underway to replace agency staff with permanent care staff members, including team leaders. A new dependency tool was in place to monitor and take action to address people's changing needs, following a significant increase in the dependency of people who had lived at the home for many years.

Although there was still significant agency staff use at the time of the inspection, this had been reduced by use of 'bank staff' employed to work at the service on an 'as and when' basis, and recruitment to some of the permanent vacancies at the home. Agency staff from two particular services were used, with regular staff attending when possible to ensure continuity of care for people. Management maintained data on the use of agency staff each month. We noted that between November 2015 to January 2016 there had been a decrease in the use of agency staff within the home. At the time of the inspection, rotas indicated that agency staff accounted for approximately twenty per cent of day time staff use. Management advised that with ongoing recruitment in place, this should fall further over the next few months.

Safe recruitment procedures were in place to ensure staff were suitable to work with people. Staff confirmed that they had undergone the required checks before starting to work at the service. We saw evidence of application forms, interview records, literacy assessments and shortlisting criteria for new staff. There were also records of disclosure and barring checks, three written references and confirmation of each staff member's identity to ensure their suitability. Training certificates showed that staff had received training in relevant health and safety topics including moving and handling, food hygiene, and fire awareness.

Staff we spoke with were clear about how they should respond to safeguarding concerns. They could describe the different types of abuse people might experience, and knew who they should report to if they had concerns that somebody was being abused. Staff demonstrated an understanding and were aware of signs to look out for indicating safeguarding concerns for people living in the home. They had received training in safeguarding adults and we saw evidence that incidents had been reported appropriately. They were also aware of the provider's whistle blowing policy and indicated that they would use it if required.

Good

Is the service safe?

Assessments were in place to ensure that risks to people were identified and addressed, and staff signed to confirm that they had read them. Risks recorded included weight loss, falls, pressure areas, and behaviour that challenged the home. They were reviewed on a monthly basis or more often if required. Only one person required regular turning, to minimise the risk of pressure ulcers, and we found records in place indicating that this was undertaken regularly. Similarly only one person required a fluid intake chart and this was maintained as required.

People told us that their medicines were given on time. Two staff were observed administering medicines during the morning and at lunchtime. We observed that some people were still receiving their morning medicines at approximately 11.00am. Staff told us that those people who were due for further medicines at lunchtime were prioritised to have their morning medicines administered by 09.00am to ensure a suitable gap. Medicines were kept in trolleys, arranged alphabetically and stored in the clinic room, locked and chain to the wall. Medicines were supplied by a pharmacy in colour coded dossette boxes where possible for ease of administration. There was a signed list of all care staff who were trained and deemed competent to administer medicines . Appropriate storage arrangements were in place for controlled drugs with a register in place with evidenced of it being signed by two staff at each administration and check. We checked the stock of a particular medicine and found that this corresponded with the records maintained. The medicines fridge temperature and room temperature was monitored for maximum and minimum levels, with all recordings within the normal range.

All medicines administration records (MAR) we inspected included a photograph of the person and information about any allergies as appropriate. There were no gaps in MAR charts indicating that people received their medicines as prescribed. Where a variable dose of medicine was required for example for people on Warfarin we found that monitoring charts had been completed and signed appropriately to ensure that they received the correct dose. However, we found two charts for people prescribed Digoxin with gaps in the recording of the pulse of the person before administration. This suggested that the recording of the pulse was not carried out consistently before administration of Digoxin to these people. This was brought to the attention of the acting manager who advised that action would be taken to address this issue without delay.

One person was receiving medicines crushed in their food, following an assessment by their GP and agreement from their next of kin due to their refusal to take prescribed medicines. However there was no agreement from the pharmacist to confirm this method of administration and it was not recorded on the person's MAR. We brought this to the attention of the management team, who provided assurance that this would be followed up with the pharmacist without delay. Medicines were being audited on a monthly basis by the deputy manager, with significant improvements reported by the local authority quality team who provided support to the home.

People we spoke with were very complimentary about the cleanliness of their room and the home in general. There were five housekeeping staff employed at the home and two laundry assistants. Where we noticed an unpleasant odour, this was generally dealt with promptly by staff, in the course of their duties. Cleaning materials were kept locked and secured, with trolleys taken into each room when cleaning. We observed personal protective equipment in place such as gloves and aprons to support infection control within the home.

Requires improvement

Is the service effective?

Our findings

People spoke positively about the staff support at the home. They told us, "I am very happy. Staff are first class," "It's a lovely home, it's a smashing home. The foods lovely, I've got a beautiful room, I think I'm blessed." Relatives were positive about staff support, although one relative noted that some staff were more motivated than others.

Staff told us that they felt well supported by the home's new management team. One staff member told us, "I am having supervision on Thursday. I do find it useful. There is good feedback and you can say what you feel needs to change or needs doing. I think things are going well." Another staff member said, "The training is very good. I have just had supervision with my line manager. It was helpful – to talk through developments and to think about what's going on and the changes."

We found that there had been some gaps in the frequency of staff supervision and appraisal sessions for care staff, particularly in the last few months prior to the new management team being put in place. Longstanding staff members had records of individual supervision from the last year, covering topics including punctuality, policies and procedures, training, and "burning issues," with an agreed action plan in place signed by both parties. However there were no sessions recorded for new staff who had started work in the home in recent months. The provider's own policy on supervision indicated that individual sessions should be provided on a two-monthly basis. We were also concerned to find that there was no record of induction or orientation information provided to agency staff who worked at the home.

The evidence above demonstrates a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff and management told us that a significant number of staff had left within the last year, and this was at least in part due to low staff morale. However this was beginning to change in recent months with the new management team, and staff described good team work and effective communication, and good support from management. Three staff meetings were held between July and October 2015 focussing on communication, trust and protecting staff from abusive language or behaviour. A general staff meeting had been held in the week before the last inspection, and these were planned to be held regularly . A daily handover meeting was held at the service, which staff said was useful for communication and problem solving.

Staff employed by the provider spoke positively about the training they had received particularly the six day corporate induction training when they commenced work. This included training in the Jewish way of life, safeguarding, privacy and dignity, equality and diversity, dementia, and person centred care, and enrolment for the national care certificate. Training monitoring records indicated training undertaken by each member of staff, identifying some areas in which training was behind, including health and safety, first aid, food hygiene, dementia, and the person centred approach. Some staff had undertaken training in sensory loss awareness, and indicated that this had been useful in their role. However there was a plan in place to provide further training in these areas. The provider's training programme was available indicating dates for further training in each area.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People said they were able to make choices about their care. One person told us, "I do things myself. I prefer it. I can get up when I want and go to bed when it suits me." There were assessments available regarding their capacity to make decisions and consent to their care and treatment. Staff had received training on the MCA but staff we spoke with were not very aware of DoLS. They could explain the process to be followed if they believed that people were not able to consent and make decisions about their care and treatment. Staff demonstrated a good understanding

Is the service effective?

of how to seek people's consent. They ensured that people with capacity to do so were supported to make their own decisions and choices, asking their permission to carry out each task. People's consent was recorded for use of their photographs in care records. There was clear documentation in place to record decisions about whether resuscitation should be attempted and advanced wishes for people living at the home, demonstrating the person's wishes and those of their relatives where relevant.

A DoLS application had been made for only one person living at the home who was unable to go out unsupervised, and did not have capacity to consent to this arrangement. There were conditions attached to this safeguard, but these were not recorded in the person's care plan and not followed exactly as specified (in the case of particular guidelines being recorded at the front of the person's care file). However we noted that the guidelines were available elsewhere in the person's care records, and further advice from a health and social care professional was being sought to clarify the guidelines further.

A review of the care records indicated that applications for DoLS and best interest assessments had not yet been submitted for the majority of people who required this. The service manager acknowledged this issue prior to the inspection, following the recent changes in management, advising that this was currently a work in progress as part of the service's improvement plan. Reference to the MCA was not found in the majority of care plans, however the new format for care plans which was being introduced did cover this area.

There were no formats in place for recording decision specific mental capacity assessments and best interest decisions made on behalf of people who did not have capacity to make a decision. For example there were no records about consent to bedrails in the file for a person who was using these. We discussed this with the service manager who advised that they would personally be providing training for all staff in the MCA and risk management, and that best interest and decision specific assessments were being introduced.

The evidence in the above paragraphs demonstrates a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were positive about the quality and choice of food served in the home. Comments included, "I am being very well looked after. The food is wonderful – I have put on weight!" and "Any food you want to change you can just change it." A relative told us, "The food is very good, always a lovely soup and a good choice of meals."

The home provided a kosher diet for people, and we observed that meal times were flexible, with people eating breakfast at a wide variety of times. People were offered choices of food and drinks, and were complimentary about the food served to them. Staff sat with people they supported to eat, and interacted with them face to face, prompting people pleasantly and in a personal way. Drinks and snacks were offered throughout the day, and a varied menu was displayed indicating a choice of nutritious food. The chef told us that ideas for the menus were collected during residents meetings, and that further work was being undertaken to improve menus, particularly looking at pureed food provision, ensuring taste while maintaining nutritional value.

People's nutritional needs were assessed and when they had particular preferences regarding their diet these were recorded in their care plan. Staff were aware of the dietary needs of people who had diabetes or who were on particular diets such as soft food. Food and fluid charts were in place for one person, to monitor the amount of food or drink they consumed. Where necessary we saw that people had been referred to the dietitian or speech and language therapist if they were having difficulties swallowing. Nutrition was monitored by monthly weight records.

We observed that breakfast in the dining area was served in a calm atmosphere with music in the background. All tables were laid with some fruit baskets to mark the Jewish new year of the trees. People were offered and chose a wide range of breakfasts ranging from fresh fruit and yoghurt, to a cooked breakfast. People were supported in an unhurried manner, and were able to have breakfast where they wished, with one person eating in the entrance hall, and others in their bedrooms. Some people had to wait for food because staff were not free to help, but they did not appear to mind this.

However lunchtime appeared to be more challenging for staff, who attempted to ensure that people were not left sitting at tables waiting for food. This was clearly difficult and we observed two tables of people waiting, due to staff not being available as they were also involved also in bringing people into the room, serving people and

Requires improvement

Is the service effective?

supporting approximately eight of them with food. In the rush one staff member appeared about to try to feed two people at once, but another support worker intervened and explained this could not be done. We saw a different support worker correcting a volunteer about the side they needed to sit on to support a particular person. These were good examples of staff clearly knowing what good care was and feeling able to intervene to ensure all were providing support appropriately. Staff confirmed that they struggled to support people to eat at lunchtime, and one staff member observed, "We rely a bit on volunteers to assist people to eat." We discussed this issue with management, who confirmed that they were aware of the problem and considering various solutions for addressing it, including the possibility of having two sittings for lunch.

People had access to health and social care professionals. They were registered with a local GP, who visited the service at least once a week, and those needing it, had visits from the local district nurse service. People who used the service receive annual health checks with their GP and practice nurse. People could see a dentist, physiotherapist, community psychiatric nurse, speech and language therapist, optician or chiropodist when needed. An occupational therapist employed by the provider was working with staff at the home to develop people's activities and liaised with other health and social care professionals in providing support to people, for example making specialist seating referrals for a number of people. They also provided training for staff in positioning, seating, supporting people with Parkinson's and swallowing difficulties. Health care professionals told us, and records confirmed that their instructions and recommendations were followed by staff at the home. Clear records were maintained of the outcome of health care professional visits.

Good

Is the service caring?

Our findings

People felt well cared for, and that they were treated with dignity and respect. Comments included, “They’re very good to me, I can’t grumble,” and “They [staff] are kind.” One person said they thought their needs were taken care of by staff, “To the best of their abilities. They are very kindly when they help feed me .. they protect my dignity and privacy.” A relative advised, “I have been coming here for years and I am always made to feel welcome. The carers are very caring with my mother, I think they take extra care because of her age.” Another relative noted, “He is always clean and nicely shaved. The carers are very nice, pleasant and welcoming.”

We observed staff across the home to be kind, attentive and friendly when talking with people living at the home. Care staff showed patience and skill at supporting people if they became anxious, and appeared to know people’s preferences well, speaking with them as individuals. We observed staff respecting people’s need for privacy and dignity, knocking and waiting for a response before entering anyone’s room. Staff demonstrated an understanding of dementia awareness, and told us that they always ensured people’s privacy and dignity was protected especially when providing personal care.

Staff were generally gentle, respectful and cheerful in manner. People seemed to feel relaxed with staff and there was some friendly banter between staff and people living at the home. We observed good interactions between staff and people they were assisting with meals, and staff sitting with people to ensure that they had eaten enough. However we did see four occasions during which people were hoisted in order to transfer, without staff speaking with them during the process, other than to give them instructions. We raised this issue with the acting manager who advised that they would address this issue with staff without delay.

One person who appeared uncomfortable after being transferred to a chair, asked us to call staff to assist, and we noted that the staff member was very pleasant and responsive to them, and tried to make them more comfortable. We also observed staff singing to one person, whilst they were being hoisted, as this was known to make them feel less anxious.

Some people were able to be involved in making decisions about their care. Care records included a place for people or their representatives to sign to evidence consultation, and record their opinion, and some of these had been completed. Records were centred on the individual person including their preferences, and some included the person’s views or those of their relatives. They included a life history with a clear indication that relatives had been involved when appropriate. Management were in the process of introducing new care plan formats with further personalised information.

In the afternoon of our inspection, a residents meeting took place in the dining room. Approximately 20 people were present and they all had the opportunity to participate. Everyone was asked their opinion of each aspect of the meeting. Lots of discussion took place and many suggestions were made including the destination for the next trip out from the home. There was a very friendly and inclusive atmosphere to this event.

The home provided support for people to practice their religion and have their social, cultural and spiritual needs met. Friday night Shabbat services were held each week and all Jewish festivals were celebrated. There was a synagogue attached to the home, which people from the local community attended. A visiting Rabbi offered spiritual support to people and their families, particularly at the end of life.

Plans were in place to improve the home environment to reflect the Jewish ethos of the home. We noted that bedrooms had been personalised. Some rooms were in need of redecoration, but there was a refurbishment plan in place to address this. Management advised that they were also looking at redesigning communal areas so that they provided a more welcoming and usable space for people living at the home.

Requires improvement

Is the service responsive?

Our findings

People were largely satisfied with the care provided to them and responsiveness of staff. One person told us, "I live like a Lord here. Everyday there is something different to do. I enjoy having people around me, I don't have to worry about a thing." Another person noted, "I like the library here as I love to read." However some people indicated that improvements could be made. One person noted, "It's very pleasant here. The people are friendly and the nurses are nice. Helpful. The only fault is that if you ring the bell at night they can take quite a long time to come. It's hard if you are unwell or need a drink." Another person said, "I do get a bit bored. I'd like to watch a few more films," and one person told us, "I don't get enough showers" but did not want us to address this with the management on their behalf.

A relative told us, "My mum's health has improved since she came here. She gets her pain relief when she needs it, her room is clean and she has two call bells, one attached to the wall and one around her neck." Another relative was concerned that their family member was unable to press the call bell, however management advised that staff checked on their relative regularly to ensure that their needs were met.

Management were aware that care records in the home required review, and were beginning to change care plans over to a new format, with more personalised information. However the majority of care plans remained in the previous format. This included some personalised information however these were not always signed by the person or a representative. Many had also not been significantly reviewed for several years, other than a monthly evaluation which frequently indicated 'no change.'

A wide range of areas were covered in care plans including a pre-admission assessment, and assessments covering falls, pressure ulcers, nutritional risk, communication, safety in the environment, mobility, bed rails, moving and handling, spirituality, and activities of living. The majority of monitoring records were in place for people as appropriate. However we were concerned to find that some actions recorded as necessary within care plans were not being undertaken, this included monthly monitoring of blood pressure and blood sugar levels for one person which were not being recorded or monitored. We also found some pressure area risk assessments (Waterlow assessments) that were out of date, with no reviews recorded in recent months. One person who we were told had complex moving and handling needs, did not have this detailed within their care plan, so this information was not recorded for staff who did not know this person.

Daily records indicated the care provided but did not give any account of people's general wellbeing and how they spent their time. There were no records kept of key-working support provided, and activity records consisted only of a letter code to identify each activity undertaken on any particular day.

There was no evidence that the instructions for staff in the care plans were evaluated to see whether they were effective. For example one person admitted in September 2015 had recorded in their care plan under communication and behaviour that staff should note interventions and methods that seemed to be effective given that the person presented behaviour which challenged staff. Evaluations recorded no changes from this date and there had been no review or consideration of how the person had settled.

Accident and incident records detailed actions to be taken to prevent reoccurrence as appropriate. However we discussed with management some of the language used in these records which was not always accurate, and indicated that management may not have reviewed these records.

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

A small number of files had been revised under the new management. These contained a good summary of 'what's important' to the person, at the start of the file and mental capacity assessments where needed. Care information was appropriately detailed whilst being concise and clearly written covering personal care, eating and drinking, mobility, toileting, cultural and spiritual and night care and risk assessments identifying risks and setting out actions for staff. There was an evaluation form for each of the areas of the care plan but as these were newly compiled files, they had not yet been used. The new care plans stressed people's choices. For example night time care plans stated preferred getting up and bed times, whether the person preferred a night light and could access a call bell and how many pillows they might need.

Requires improvement

Is the service responsive?

We overheard one person who sounded distressed during personal care, being supported by two people. The situation was handled well, with staff calming the person and encouraging them to participate in their care. Observation of this person's care file indicated that staff had followed guidelines for supporting this person appropriately, indicating that they were clear about people's individual needs. Staff told us that they tried to respond within three minutes of a call bell. This was not observed during this inspection as most of the residents were in the dining/ lounge areas.

People were given a variety of choices about how they spent their time. During our visit we observed a small group of people sitting around a table engaged in an arts and crafts session, with support from two volunteers. There was a good deal of conversation between the group, ensuring that all were engaged. One person told us that they were she was part of the home's choir which had won a competition last year. This lady also spoke of her enjoyment of the weekly quiz. We observed that daily papers were available for people to read, and the 'Jewish News' was also provided. The activity programme set out for the day included a reminiscence session, residents meeting, hairdresser and a reading group. This was also available in an easy read version. This programme was also available in the home's lifts, alongside adverts for a visual art group and the residents meeting.

We spoke with the social support worker, who coordinated activities at the home, and had a wide range of photographs of people engaging in various events organised. She was in the process of compiling detailed life histories for people living at the home. A large display of photographs printed onto fabric depicting the weddings of some of the people living at the home. The coordinator explained how this wall hanging was achieved, and how people's faces lit up upon seeing their wedding pictures displayed in this way. She noted the invaluable support of volunteers from the local community in supporting group and individual activities within the home, and advised that the service was reviewing the list of activities it offered and trying to fill some of the gaps in the volunteers timetable. We met with the home's occupational therapist who was working with the social support worker to provide more bespoke support with activities for people living at the home. They noted that two new Ipads had been purchased for the home, to support individual people to access the internet, and they were purchasing more sensory equipment for use in the home.

Care records included activities which were meaningful to each person. This included music, chair exercises, reading groups, bingo and sewing. Outdoor activities included a visit to Canary Wharf. The home's diary included recent or planned trips to a local shopping centre, 'Rosie's little Bubalas group' (where people brought in their babies, which was very popular with some people living at the home), musical therapy, visual arts, discussion groups, a Valentine's day party, Mother's day entertainment, baking sessions, and committee meetings. Management advised that new activities care plans were to be developed for each person.

People were aware of the home's complaints procedure and told us that they felt able to complain if they were unhappy about anything. They told us, "If I have a complaint I go to a carer. They normally sort it out," and "No complaints. I don't want to be here but its fine here. I am content with the care. If I had to complain I would go to the manager and am confident it would be addressed." They were also able to raise any concerns at residents and relatives meeting held at the home. We found that there was a clear record in place of all complaints received since the last inspection, including details of action taken to address them. There was information displayed in the home explaining how to make a complaint.

Records showed that complaints were taken seriously, and the service upheld complaints where these were found to be substantiated. However records did not always indicate what changes were made as a result to ensure that there was no repetition of the issues raised and that learning was taken forward. Issues raised in recent complaints included the quality of food, the home environment, and laundry care. We observed that senior management met repeatedly with one person who was unhappy in a number of areas, and liaised with their family in order to address their concerns.

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Is the service well-led?

Our findings

People and their relatives were positive about the home's management, although some people were confused due to having had different managers in recent months. They told us that there was a good atmosphere and good communication in the home. Relatives told us, "They do their best," "Yes she [the interim manager]'s very nice, I'm comfortable with everything the home does," and "some aspects are great, but it is hard to get in," and "X [the deputy manager] is trying to bring about changes." One relative did not think that the service represented good value for money.

Since the previous inspection the registered manager had been on long term sick leave and was no longer working in the home. The deputy manager had left the home in October 2015, and a significant number of staff had left the home which staff and management indicated was partly due to low morale. The new service manager for the home, had started working on a service improvement plan since August 2015, and had put in place an interim manager, and a new permanent deputy manager to lead the home. They advised that they were in the process of recruiting a registered manager for the service. They had worked with support from the local authority's integrated quality in care homes team, to bring about improvements, particularly to the home's medicines management. People using the service, relatives, staff and health and social care professionals felt that the new management team had made positive changes, and created an open and inclusive atmosphere. There were posters around the home asking for feedback, and a copy of the 'residents' charter' in the lifts. The service also produced a regular newsletter about the home for people using the service and their relatives.

Staff said they found the managers to be very supportive and visible around the home. One staff member told us "The new managers are more hands on and involved. They are here early in the morning, they positively interact giving good feedback." Another advised, "The management are supportive and its good leadership. They are positive about care now. They are proactive. Having them on board helps the quality of care here." Regular staff meetings and daily handover meetings were in place, at which staff could discuss any issues, and receive feedback from managers. Staff said they were able to raise concerns if there was a need. Weekly senior team meetings were held, to discuss progress with the improvement plan for the home, and any issues arising. Two dementia champions had been appointed for the home, to provide leadership by demonstrating good practice to the staff team.

Health and social care professionals had noticed improvements within the home, including better information provided in care plans, more hands on management, improved medicines management and improved communication with the home.

We saw records of internal audits relating to the service. A recent financial and administrative compliance audit awarded the service 93 per cent in compliance, with a small number of areas for improvement including the need for two staff signatures on every petty cash voucher, and restrictions on the amount of money to be stored in the safe. Clinical key performance clinical indicators were measured monthly, and the management were aware of further work needed to address areas highlighted including recording advanced wishes for more people.

The most recent service monitoring report by the provider was undertaken in October 2015 by the business manager, including observation and feedback from people using the service, relatives, staff, volunteers and management. Areas for improvement identified included food provision, activities, the 'Jewishness' of the home, the décor and furnishings, lack of management at weekends. As a result of this audit, an action plan was put in place which included management now covering the home on Sundays. Significant refurbishment was planned for the home, and changes had been made to menus and activities provided.

A survey was being distributed to people regarding the 'meaning of Hamishe food' to them. The plan was to collate recipes from people living at the home to be incorporated on the home's menu, and also to produce a recipe book for the home, which could be used for fundraising.

The most recent survey for people living at the home was conducted from August to October 2015 with 16 people completing questionnaires, indicating a high satisfaction rate. The relatives survey from March 2015 received 26 responses, with people rating the service highly for the kindness of staff, dignity, respect, safety, activities, and Jewish atmosphere. Areas needing attention included

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Is the service well-led?

furnishings with only 33 per cent satisfaction, and how easy it was to speak with senior staff at 77 per cent. Satisfaction with food, homeliness and cleanliness was rated at 88 per cent.

We saw evidence that the service improvement plan was being implemented, with progress made in improving communication between staff, management, people using the service and their relatives, addressing complaints and safeguarding issues. The management team were aware of further work needed to recruit more staff, develop team leadership, empower people using the service, improve the physical environment in the home, comply with the mental capacity act, and improve care records within the home.

Current records were available of gas safety and electrical installation certificates, portable appliances testing, water testing, lift and hoist servicing, fire equipment servicing and regular fire drills and call point testing.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People using the service who were unable to give informed consent were insufficiently protected by the home's procedures to ensure that all decisions were made in their best interests within the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and monitoring records were not sufficiently detailed and precise, in order to ensure that people's needs were fully and responsively met. Regulation 12(1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff employed by the service provider did not receive sufficiently regular supervision and appraisal, and agency staff did not receive sufficient induction and orientation to carry out their role effectively. Regulation 18(2)(a)