Jewish Care

Lady Sarah Cohen House

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

Summary of findings

Overall summary

This inspection took place on 18 and 24 April 2018 and was unannounced. Lady Sarah Cohen House is operated and run by Jewish Care, a voluntary organisation. Lady Sarah Cohen House is registered to provide accommodation for up to 120 people who require nursing or personal care and treatment of disease, disorder or injury.

People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. There were 94 people living at the service on the day of the inspection, the majority of whom were over 65 years of age with disabilities.

We last inspected the home on 4 and 9 January 2017 when we found the provider was in breach of three regulations, in relation to staffing levels, governance of the service and the safe management of medicines. At this inspection we found improvements had been made and the service was no longer in breach of any regulations.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the CQC 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.

People using the service told us they felt safe at the service. There were systems and procedures to safeguard people from abuse and staff had a good understanding of their role in protecting people from harm and abuse.

We saw staff were kind and caring and people told us this was the case.

Medicines were safely managed at the service; stocks tallied with records and were stored appropriately.

Recruitment checks and other related documentation required were in place prior to staff starting work, so staff were considered safe to work with vulnerable adults.

We found there were enough staff to meet peoples' needs.

Care records were detailed and together with risk assessments provided guidance to staff in managing people's needs.

There was a choice of menu and food was of a good quality, prepared in line with Kosher dietary laws.

There were quality audits in place which covered key areas including medicines, care plans, staff supervision

and the service offered at night. There were effective management systems in place to ensure training took place, and there was compliance with health and safety issues.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We have made two recommendations in this report. We have made a recommendation about the provider obtaining the views of people regarding their personal experience of care, and that they review their medicines policy and practice.

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. People told us they felt safe and the service had safeguards and processes in place to protect people from abuse.

There were enough staff to meet people's needs.

Risks were identified by the service and addressed in care records.

Medicines were safely managed.

The service followed safe recruitment practices.

Is the service effective?

Good

The service was effective. Staff received regular supervision and training to support them in their role.

Food was nutritious and varied, in line with Kosher dietary laws.

People had access to good health care.

Staff understood issues of consent and the service was compliant with Mental Capacity Act 2005 requirements.

Is the service caring?

Good

The service was caring. We saw staff were kind to people and people confirmed this was the case.

People were supported to maintain relationships with family and friends, and people's cultural and religious needs were met by the service.

Care records promoted people's independence, and people told us they were involved in planning and making decisions about their care.

People's end of life care wishes were discussed and documented.

Is the service responsive?

Good

The service was responsive. Care plans were comprehensive and reviewed regularly.

There were a range of activities across the service for people to participate in.

The provider had a complaints process in place and we could see that complaints were dealt with in line with the policy. There were numerous compliments about the service.

Is the service well-led?

Good

The service was well-led. There were audits taking place across the service, and breaches identified at the last inspection had been addressed by the management team.

Staff told us they were involved in the running of the service.

Communication with relatives was extensive, but the systems for gathering the views of people using the service needed to be reviewed.

Lady Sarah Cohen 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.

This inspection took place on 18 and 24 April 2018 and was unannounced. The inspection was carried out by three adult social care inspectors, a pharmacist inspector, a nurse specialist advisor and two experts 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.

Prior to our inspection, we reviewed information we held about the service, including previous reports and notifications sent to us at the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We looked at the information sent to us by the provider in the Provider Information Return. 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.

During the inspection we spoke with 16 people using the service and 11 relatives. We later spoke with two additional relatives.

We spoke with the registered manager, deputy manager, service manager, assistant director of care services; eight care staff, seven nurses, and three other allied health professionals, including speech and language, and physiotherapist staff. We spoke with staff responsible for maintenance, food preparation and the kitchen, and housekeeping across the service.

We checked 11 records related to care provision, including nursing records, for example, wound, positional charts and risk assessments. We looked at 20 medicines administration records, and other medicines management documentation. We also looked at storage of medicines and checks stocks against records.

We looked at training records for the team, supervision records, recruitment for four staff members and activities documentation for people living at the service. We examined safeguarding and quality assurance

documents as well as meeting records for staff, relatives and people living at the service.

We spent time on both days of the inspection observing how people were supported with lunch, and with provision of care in communal areas.

Following the inspection we spoke with the 'living well manager' who co-ordinated activities, and the management team sent us additional documentation including staff rotas.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. They told us "Yes I am." And "I am not scared here." "Yes, I feel safe; just in the fact that I don't feel unsafe!"

We could see the service had systems in place to safeguard people from abuse. Staff told us they had received training on how to identify and manage any suspected abuse of people who used the service. They gave examples of abuse and they were able to describe the types of abuse that may occur in a care setting. Staff also demonstrated an understanding of signs and symptoms of abuse and explained how they would report these. Staff told us "If I ever had any concerns I would immediately report them to the registered manager or our safeguarding lead." And "Management always act immediately if we report any concerns."

The whistleblowing policy was in the staff room and confidential disclosure reporting telephone numbers were clearly placed so staff could access them. The provider had recently received information from a whistle-blower and we were able to confirm by reading records provided that the incidents were robustly investigated.

We were able to discuss training with staff who had all attended safeguarding awareness courses during their induction and regularly thereafter. One staff member told us "the safeguarding training was excellent, I learned so much." All staff members were presented with a leaflet which they carried with them whilst at work. This leaflet gave essential information on mental capacity, data protection and safeguarding.

The provider had systems, processes and practices to safeguard people from abuse. Safeguarding concerns had been dealt with appropriately. The provider had worked with other professional bodies such as the local authority, the Tissue Viability Nurse and where required, the police. The provider had attended safeguarding planning meetings and assisted with the safeguarding process.

To monitor, review and share best practice across the organisation the provider had recently introduced a new Safeguarding Register to record all safeguarding concerns and these were discussed at a Safeguarding Panel. This enabled the provider to have a strategic overview of all safeguarding incidents and consider individual and thematic learning for services.

At the last inspection we had found a breach of the regulations as medicines management was not always safe. At this inspection we found medicines were in the main managed safely, however we saw that PRN (when required) protocols were not patient specific and medicines being given covertly were not administered in line with the provider's policy.

People that needed to take medicine only when required, had protocols in place to provide staff with information about when the medicine was to be given. However, we saw that this information was not specific to the person, which meant people may not always be given their medicine when they needed them, for example if they were in pain. The PRN protocols we looked at did not include information about whether the person was able to ask for the medicine or if they needed prompting or observing for signs of

need. The medicines policy did not outline the information required in the 'medicines when required' protocol. Since the inspection, the registered manager has provided evidence of amendments made to the 'PRN protocol document to allow additional information about signs and symptoms to be included. The provider had personalised all the PRN protocols by the time of writing this report.

We also found the service was not administering medicines covertly in line with the provider medicines policy. People who actively refused their medicine but were judged not to have the capacity to understand the consequences of their refusal, were administered their medicines covertly. This was carried out after a mental capacity assessment and best interest decision had been made. Records of decisions to administer medicines covertly were completed with the information from GPs, pharmacists and any appropriate advocate of the person. All records stated that trained nursing staff would covertly administer the medicines. However on the day of the inspection we saw that a nurse had prepared the medicine for a person and given it to the carer to administer covertly in line with the care plan for this person. The nurse later came and checked with the carer if the medicine had been administered. This did not follow the provider policy.

We recommend the provider should review the policy on managing the process of giving medicines covertly to ensure this is aligned with current practice.

Medicines were stored safely and appropriately including medicines needing refrigeration and controlled drugs, which require additional security. Weekly medicines and controlled drug audits were carried out by senior nurses on each floor. We saw that the supplying pharmacy had carried out a medicines audit and the care home was working on addressing actions derived from the audit.

MARs were clear and medicines were recorded accurately. We saw that each person had a photo to aid identification and information about their allergies and how they liked to take their medicines to support staff. Care plans were in place and these were reviewed monthly. Many people were due a review of their medicines by the GP or pharmacist. We discussed this with the registered manager who agreed to discuss this with the health professionals to set up a review.

Nursing staff received medicines training and had their competency assessed to ensure they could handle medicines safely. We observed nurses give people their medicines.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks before they employed new staff to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. Where proof of permission to work in the UK was required, the relevant checks of the applicant's status were carried out. We saw that nurse registration checks were also carried out regularly to ensure they were registered with the Nursing and Midwifery Council.

Risks were addressed either through risk assessments or care plan documents so staff were guided in how to care for people safely. These described potential risks and the safeguards in place to reduce the risk when providing care. For example, where a person was at risk of falling out of bed, bed rails were fitted. There were moving and handling risk assessments in place and we found there were malnutrition universal screening tool, (MUST) risk assessments in place and up to date. The service used Waterlow; a pressure ulcer screening tool to assess people at risk of poor skin integrity and a care plan was developed to address these risks and needs.

At the last inspection we found there was insufficient staff to meet people's needs. At this inspection we

observed there were enough staff to meet people's needs. However, the service still needed to review how staff were used across the floors, as people still had concerns regarding staffing levels.

Following the last inspection the registered manager told us they had reviewed people's dependency levels, and had increased staffing levels from eight care staff and two nurses on each unit of 37-40 people to ten care staff and two nurses on each floor in the day and two nurses and five care staff at night. Some people required 1:1 support from staff so this was commissioned separately. The service had also enlisted additional volunteers to support people at mealtimes so people did not wait long for food. We did not see people waiting for long periods at meal times on the days of the inspection.

The registered manager also told us they had introduced the role of team leader since the last inspection. The team leader had management duties but would also help with care when needed. The service also employed an extra member of the staff team on duty for planned admissions, so that they can be available to "meet and greet" and help the new person and their family members, get settled.

However, six out of sixteen people told us they thought there were still some periods when there was insufficient staff. They told us "There's a problem with going to the toilet. I need two people to help me and I have to wait." Another person said, "If I want to go to the toilet, I just want to go and I can't get help quickly." Other people referred to other periods when they thought the service could benefit from additional staff, these included meal times and period when they wished to access the garden.

Following the inspection the deputy manager discussed with care and nursing staff people's toileting requirements on each floor to identify if there were any patterns to people's requirements to ensure their needs were met and committed to keep this as an ongoing discussion.

We recommend the provider develops reviews their systems for staffing and to obtain regular feedback from people regarding their personal experience of care.

We checked the rotas for the two week period from 17-31 March in detail checking each floor's staffing both day and night. We found there was often more staff commissioned in the day; this was for people who required one to one support or for staff accompanying people for appointments.
Some staff on the first day of the inspection told us they had to wait for a hoist before providing care to people. We did not identify this as an issue on the second day of the inspection but the Registered Manger told us they would ask staff views about equipment and whether this impacted on the time taken to provide care. They also told us they were reviewing dependency levels of people living on each unit, the staffing levels and the utilisation of staff time as part of the implementation of the new electronic care system. This would provide an additional tool to check staffing levels.

People told us that they preferred being cared for by staff who understood their needs well. The service used a mixture of permanent staff, long term agency staff and short term, agency staff. One person said "There is too many agency staff. They don't know your needs unless somebody tells them." Another person said, "There is more agency staff at weekends." One relative told us the permanent care staff and the regular agency care staff were kind and patient but they sometimes found the agency staff used for a single shift "off- hand".

The two week period from 17-31 March showed us that regular agency staff were routinely used at the service. New agency staff were employed on occasion, not usually in significant numbers, but used more on one floor than others. This may explain why for some people they perceived a high level of new agency staff, over other people, who did not see this as an issue.

We discussed recruitment of staff with the Assistant Director of Care. They told us they had been working to recruit additional permanent staff and were exploring additional ways to address recruitment issues across the service. The service attempted to use regular agency staff so they were familiar with people's needs. The service had 'preferred agencies' they contacted when they were short staffed and held a folder of regular agency staff used, with their training profiles and evidence of induction.

We checked accident and incident forms and could see that these were signed off by the registered manager or deputy manager. A specific safeguarding event last year had prompted a number of changes at the service and the management team showed us through records they were committed to ensuring learning took place in relation to incidents and safeguarding events.

People lived in an environment that was safe, secure, clean and hygienic. We saw that there were regular checks to maintain the safety of the premises including gas and electrical appliances. Equipment used by people, such as hoists were serviced in line with manufacturers' guidelines.

The maintenance manager explained how the provider completed daily checks of the building. Any hazards were immediately reported and risk assessed. The care home had a contract with an external maintenance provider who had agreed set response times for action dependent on risk.

People were protected from the spread of infections. The provider had separate cleaning regimes for different areas of the home and different coloured cleaning equipment to avoid cross contamination. Staff were also given protective clothing to wear when completing personal care and gloves when serving or preparing food. We spoke with three staff about hygiene and all were able to explain how they minimised cross contamination. One staff member said; "We have all been on training, infection is something we take really seriously." We noted staff had completed infection control training as part of their induction.

People told us the service was clean, "It's spotlessly clean," another said, "It's clean." Relatives also told us they thought the service was clean. There was no malodour in any area, on any day of the inspection.

The provider had systems to check the fire safety systems were functioning safely and we saw these were carried out. People had detailed individual personal evacuation plans in place which detailed the support they required to evacuate the building in the event of a fire. Staff were aware of what to do in the event of a fire and who to contact. Staff had all completed fire training; the most recent refresher training had been completed in March 2018.

Regular fire drills were conducted and were monitored by an independent consultant. We saw written evidence of how the provider had modified its fire procedure following advice from the fire consultant. This showed the provider was continually reviewing the safety of the people who used the service. One staff member told us "The fire brigade have observed our practice, we continue to learn."

Good

Is the service effective?

Our findings

The provider ensured staff were trained in key areas to carry out their caring roles, and they received regular supervision and appraisal to provide personal development opportunities for staff at the service.

Mandatory training included fire safety, person centred care, mental capacity, control of substances hazardous to health (COSHH), moving and handling, safeguarding vulnerable adults and emergency first aid. Staff also undertook training in, food safety, Jewish way of life, issues of consent; Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff told us that the induction programme was comprehensive and included training to ensure that they had the necessary skills and knowledge to undertake their role. New staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

The provider supported staff to develop and a number of staff we spoke with had been supported to achieve nationally recognised qualifications in care. Two staff had joined a programme to convert their overseas nursing qualifications to those accepted in the UK. A further two nurses were due to start on the programme. The provider had recently been part of a 'Teaching in Care Homes' pilot, a scheme to improve training for staff in care homes.

The provider offered placements to student nurses and there were four on site at the time of our inspection. Placements were between four and six weeks in length; students were supernumerary to the staff rota and they worked alongside a qualified nurse at all times. This provided additional staffing for the floor, whilst best practice could be shared by both student nurses and permanent nursing staff at the service.

Volunteers were also offered training. We saw a schedule of courses available for staff and volunteers in the arts and disability team covering dementia and behaviours that challenge. This was to ensure all staff and volunteers understood how best to support people living at the service.

One staff member stated, "I have to say our training, it's great and really informative." A second staff member told us "I found the training in dementia particularly useful. We were also told, "Training is excellent here, I attend regularly."

Staff were supported in their role and received regular supervision and an annual appraisal. All staff appraisals were up to date. Supervision notes were detailed and relevant to people's roles. Regularly used agency staff also received supervision, the deputy manager told us "once they are on the floor, they are our staff and should be supported in this way."

There was also a system of group supervision 'reflective practice' where the senior nurse met with a group of care workers to collectively discuss complex issues. Minutes evidenced discussions in relevant topic areas, for example, how best to support a person at the end of life or managing behaviours that can challenge.

Care workers were often asked to lead the reflective practice session. This included presenting a challenging case, which helped to develop their confidence and prompted them to consider the many different aspects of a person at a greater depth.

People told us they thought the majority of staff had the knowledge and skills to care for them. Two people told us "Yes as far as we know [they have the skills]," And "They all seem pleasant. There are a nice lot on today." Two family members told us their relative's health had significantly improved since being at the service and they were very grateful and praised the care provided. One relative told us "He's getting absolutely wonderful care."

People had good access to health care both at the service and from external health professionals. The GP visited each floor once a week. The service employed an extra Registered Nurse on duty on that day to assist the GP, takes records for the home and do any follow-up required, as well as telephoning family members with any updates from the appointment. If people need to see a GP urgently in between weekly visits they can, when the GP visits the other floor.

There was an on-site speech and language therapist (SaLT), physiotherapist and counsellor who worked closely with care staff in order to maximise people's potential and well-being. There was a physio gym for the benefit of the residents. This contained exercise bikes specifically for residents with Parkinson's disease as its use is beneficial in reducing the impact of tremor for people with this condition. At the time of the inspection there were 20 people with this condition at the service. The gym also had parallel bars to re-educate people's gait and increase confidence. All physical exercise at the gym was supervised by a trained health professional.

We attended a multi-disciplinary team (MDT) meeting which was held each month. This was chaired by a social worker from the provider and included SaLT, physiotherapist, members of the staff team and a counsellor. A nurse and healthcare assistant presented cases from their floor. Discussions took place regarding the care of people with complex needs or where people's health had significantly deteriorated or where staff needed guidance on ways in which to offer better support the person. This meeting gave careful consideration to each case presented. It was evident that those cases discussed were well known to most staff.

We saw evidence of referrals to other professionals such as psychiatry and optician. Some people at the service and one relative told us they had problems accessing a dentist.

We discussed this with the registered manager who told us they could take people to appointments locally for dental care, but had not found a dentist willing to visit the service. This meant not all people at the service were easily gaining access to dental care. The registered manager told us they were about to start a new oral health programme, which would involve staff paying more attention to this area of care, and sourcing better dentistry facilities locally. Staff training had begun and care plans were to be updated in the coming months to address this area more effectively.

The service had systems in place to manage pressure area care. Records showed that people were turned in line with care plans to ensure skin integrity was managed. Equipment including air mattresses was used where required, and we saw these were checked regularly to ensure they were at the appropriate level. Referrals were made appropriately to the tissue viability nurse service and dermatology service, for additional guidance when required.

We found one person had been discharged back to the service from a local hospital and now required additional equipment to manage their pressure ulcer care. Although the care plan had not been updated to reflect this on the first day of the inspection, we were aware by the second day of the inspection that the care for this person was being managed effectively and training for staff in use of this equipment was due to take place. The registered manage rtold us they would take any learning from this incident and share it across the service.

We checked how the service supported people with tube feeding directly into their stomach, percutaneous endoscopic gastrostomy (PEG) feeding. We saw that nursing staff knew how to use the equipment safely to feed this person and staff had knowledge of how to maintain hygiene in relation to the equipment. We could see the service involved specialist nurses appropriately to support this process. One person who required use of a PEG to get nutrition also chose to eat some foods although they were at risk of aspiration. We could see that the staff supported this person to have food against the advice of the SALT due to safety concerns. But this person was able to make this informed choice and this was respected by the staff at the service. Documentation was in place to guide staff in the action to take should this person show signs of choking as the person also refused suction.

This was evidence that the staff were able to understand the complex issues regarding consent when providing care to people. At the MDT meeting we witnessed a discussion regarding another person, where the person had capacity, but some staff expressed discomfort with the 'unwise' choices being made by the person. They were offered assurances by the MDT that staff were following guidelines and continuing to offer good care whilst respecting this person's capacity to make choices for themselves.

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 saw documentation which showed people's mental capacity was considered as part of the pre admission assessment, and as part of peoples' regular care reviews. Applications to restrict people's liberty were submitted to the local authority if these were required. We saw DoLS authorisations from the local authority in place and the management team had a system to prompt renewals.

We saw how the provider held a list of all people who lived in the home who had been assessed as lacking capacity to make decisions in a particular area of their life. This system enabled them to have a reference should there be concerns with issues of capacity in relation to care provision.
We saw people were asked to consent to care and support before this was given. However where people were unable to give consent we noted the provider had organised meeting with families, representatives and associated professional working with the person to make best interests decisions for care to be provided. Staff demonstrated an awareness of the importance of gaining people's consent and confirmed they had received training in these areas. They were aware if a Power of Attorney had been issued and this was noted in care files.

People told us regular staff were better at getting consent before providing care to them than agency staff

that were unfamiliar with the people living there. Relatives also noted the difference between regular permanent or agency staff and staff who were working single shifts at the service. One relative said "Not always, some do some don't. Sometimes they take people in their wheelchairs and don't say they are moving them. There is a whole mixture of staff."

Some of the people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place, Records we saw were up to date and we saw where family members had Lasting Power of Attorney, they were part of the decision making process.

The service provided food in line with Kosher dietary laws and people's food and hydration needs were met. The rabbi, in attendance at the service on the first day of the inspection confirmed that all food was at an acceptable level of Kosher, and was stored and presented appropriately.

The majority of people were happy with the food. People told us "I'm happy with the food. The food's freshly cooked. Yes, there's a veg option." Another said, "Yes and there's a choice most of the time." One person who was on a soft diet told us "The food's marvellous. It's done very well and I can feed myself." One person told us "It's OK; not much choice. I'd like to have coleslaw and I like salads."

Menus were displayed in the dining areas and people were asked on a daily basis what they would like to eat. They were shown pictures of alternative meals and were shown sample meals to assist them in deciding. Lunchtime was a very relaxed and happy occasion. There were many staff assisting people to eat and this was done in a safe and professional way, with lots of friendly chat and laughter between staff and those who used the service.

The registered manager confirmed food choices are discussed at residents' meetings and there was a "food forum" to see if any improvements could be made. Care records recorded what food people disliked or enjoyed.

People who had been identified at risk of future health problems through weight loss or choking had been referred to appropriate health care professionals and were weighed regularly. Nutritional risk assessments were in place and reviewed monthly for people at risk of malnutrition. Fluid charts were completed and reviewed for people at risk of dehydration. Advice sought from dietitians and SALT was clearly recorded.

The chef had a system to cater for people's specialist dietary requirements and there was a separate area of the kitchen for specialist food. The provider had a specialist chef for pureed food. This meant that care was given to pureed food and the provider had a contract to provide this service to the NHS.

There were snacks available all day throughout the home as there was an area in each living room with food and drink stored. We were not sure people were fully aware of these but we discussed this with the registered manager and deputy manager who agreed to reinforce to staff the need to continually offer drinks and snacks to people on each floor.

The building was purpose built, so is fully wheelchair accessible throughout with dining and lounge areas on each floor. All the floors are accessible via lifts and there is an accessible garden. The home shares kitchen and laundry facilities with another care home from the same provider. The home is part of the Betty and Asher Loftus centre, a community hub with access to a synagogue, shop and a café.

Good

Is the service caring?

Our findings

People told us the majority of care staff were kind, caring and patient, particularly permanent staff or regular agency staff. This was confirmed by a number of relatives who made the same distinction. One relative told us in her view all the staff "were wonderful." One person told us "They're very caring and marvellous but they have to do too much." A staff member told us "What's important is that the residents are happy."

We saw that care records highlighted people's preferences regarding their daily routines and the gender of care staff to support them. People had several keyworkers. If a keyworker was working a shift they were assigned to care for the person. This was positive for people as staff were able to tell us what type of care people liked; of particular importance if people have memory problems, or were unable to tell you what they wanted. We checked care records after discussions with staff and this confirmed they understood people's preferences. People's personal histories were recorded on care records and staff were able to tell us about people's past and who was important in their life now.

Care records detailed what skills people had and encouraged independence. For example, one person whose care records noted their complex medical and physical problems also noted this person could brush their teeth if given a toothbrush with paste on it, and prompted to do so.

On the first day of the inspection we saw some staff going into people's rooms without knocking as they were looking for other staff to support them in their caring role. We discussed this with the registered manager who assured us this was not usual practice and we did not witness this on the second day of the inspection.

We saw staff interacting with people in a kind and caring way. For example, staff very gently woke a person in time for their lunch. This was done by softly calling their name and taking time to ensure they were fully awake before assisting them into the dining area.

We asked people if they were treated with dignity and respect. The majority of people said they were, comments included "Yes they do," and "Always." One person told us "A lot do. There are the odd few who don't. Some are truly dedicated." People's rooms were personalised as they chose.

People's cultural and religious needs were met by the service in a number of ways through the provision of food in accordance with Kosher dietary laws, access to synagogue weekly and a rabbi on a regular basis. The service celebrated Jewish festivals and days of observance and family members were encouraged to be part of people's lives at the service.

We spoke with a rabbi who visited the home up to six times per week. They told us part of their role was to ensure people's wishes were known and respected. They described their role as that of a 'people's champion, looking after their spiritual and emotional well-being without being over-bearing'. They told us they had the full support of the staff group who frequently asked them to visit a person whom they considered in need of some comfort.

We were told how the provider facilitated the marriage of a resident's daughter in the on-site synagogue since the resident was too frail to leave the home. This occasion was celebrated with many of those who lived in the home and in a neighbouring home.

Relatives and friends were welcomed at the service. One person told us "Yes there is 24 hours 7 days a week access." A relative told us "When my mother was very unwell I stayed three nights, it was amazing how they looked after her." This relative also appreciated being able to stay with their mother.

Although there were no double rooms available, the service could support couples to maintain their relationship, and accommodated them taking into account people's physical needs and the potential for safely providing care. The service would be happy to look at each circumstance on an individual basis.

People's signatures were not always evident on individual care plans, but people told us they were involved in care planning. Relatives also confirmed this. "Yes I know what mum wants. I have signed the care plan." The registered manager also told us the service was in the process of moving to electronic care records and this involvement would be evidenced on the new system.

We noted on the first day of the inspection that the communal bathroom with the only bath in this service was not available for use, as the room was used for storage. The registered manager told us one person who enjoyed having a bath was invited to use the facilities in the sister home in the same building. By the second day of the inspection the communal bathroom had been cleared, and following the inspection the deputy manager ensured that everyone's preferences for bathing or showering were discussed and noted on their care records.

We saw that people using the service were part of the recruitment panel for the deputy manager employed within the last 12 months which was positive.

Good

Is the service responsive?

Our findings

The provider was in the process of introducing a new electronic care system to the service, which they planned to fully implement by November 2018. The service had been prioritising new admissions to the service for use on the new system and those people whose care needs were not complex to ensure staff were fully familiar with the system before rolling it out fully. We looked at paper based care records and then examined the electronic care system for specific information to check the care being provided.

Care records were detailed and covered a wide range of key areas including moving and handling, personal care, continence, skin care, dietary and fluid requirements and communication. For example, one communication support plan explained one person had communication difficulties due to being hard of hearing and having dementia. Their support plan described how they communicated and what method of communication worked best for them. For one person, staff were directed to observe their non-verbal gestures and body language in order to understand their wishes.

For people with complex medical conditions, there were additional care plans addressing wound care, how to manage pressure areas or equipment necessary to support people. For example there was detailed guidance in how to clean the machine that provided nutrition directly into a person's stomach. People had their own slings and sliding sheets for moving and handling purposes.

The provider ensured that people received personalised care through a mixture of care records and staff knowledge. This was evident when we spoke with staff who were able to tell us about people's preferences. A new key worker system had been developed since the last inspection. We could see that regular agency and permanent staff were familiar with people's needs but the paper documentation for agency staff was very brief. We asked how new agency staff were supported to understand people's needs. We were told they worked alongside experienced members of staff and were often familiar with electronic care systems so could use these for information. One agency staff member told us "The manager will not let us work alone until we prove we have familiarised ourselves with the residents."

The new e-care plan documentation linked to risk assessments and also used a flagging system to alert staff to critical elements of care. For example, when a member of staff looked at the electronic care record for personal care, they could immediately see what had been written regarding what personal care they require, at what time and if for example, they wish to have their hair washed. The tick list on the system showed what care the resident had received.

We saw that regular monthly reviews of care took place by staff in relation to specific needs, including people's health care needs. The monthly review followed the "Resident of the Day" system, that was, people in specific room numbers had their care reviewed on a specific day of the month. The service found this to be a helpful prompt for staff and was successfully embedded in the home. Once a care plan was electronic, warnings would be posted if a review had not been completed. These flags were seen by all managers.

Annual review meetings were not recorded in full on care records. Instead, people or their relatives signed to

say they were happy with the care plan for the coming year. We discussed this with the registered manager as this did not evidence that there had been a comprehensive review of overall care for people on a regular basis. The registered manager told us they were piloting a paper format for review with a small number of people at the service. They also told us family members and friends provided a source of feedback on care provision, for the service.

We asked the registered manager how they would ensure people's views were obtained and they told us the new system would have the ability to record resident's feedback at the time of providing care. This would go some way to obtaining feedback but would be completed by the person providing care at the time. The registered manager told us once the new system was up and running the deputy manager would run a weekly report on resident feedback which would be discussed at each floor's care review meeting.

The service had an extensive range of activities for people, both at the service and externally. In the last year outings to Woburn Safari Park, the RAF Museum, restaurant trips and a boat trip had been available. People had the opportunity to go out to concerts as well as musicians coming to the service and playing a range of live music, from classical to songs from the 1930's, 1940's and familiar Jewish songs. On the second day of the inspection there was a group of classical musicians playing for people on each floor and also in individual resident's rooms. We could see people enjoyed hearing the music.

Although we could see from minutes earlier in the year there had been some issues, people were generally positive about the activities. Comments included "The activities are very good. A trust pays for the concerts from outside." "I love the activities, music, debates; I want to go to all of them." Another person told us "I can't walk so I like to listen to music in the company of other people." Relatives were, in the main positive about the range of activities at the service. One family member said "There are activities that she enjoys like professional concerts. During Passover lots of school children came in to visit."

Internal activities were varied and included discussion groups, intergenerational work with a local primary school, flower arranging, watering the plants, manicure, quiz and word game leaders, hairdresssing, bridge players and young musicians.

Volunteers also assisted with mealtime support, massage, manicures and the running of the synagogue on site. As the service is located on a site with other Jewish Care services, the provider had volunteer's managers who ensured the appropriate paperwork and checks were in place before volunteers started working with vulnerable people and who inducted, supervised and supported volunteers in their caring role.

The service was located around a large garden area which had differing sections for people to sit in. Some people told us they enjoyed use of the garden on a regular basis; other people told us they would like greater access to the garden. We discussed this with the registered manager who told us they would ensure people's preferences in this area were acted upon so people could go outside in the good weather when they wanted.

The service provided end of life care and some people even moved to Lady Sarah Cohen House for this service. As well as DNACPR, we saw some people had 'advanced wishes' in place, which were designed to be used when a person is not able to express their preferences at the end of life. In one case, two family members, both of whom had Lasting Power of Attorney, completed the advanced wishes document. This included the preferred funeral director, whether they wished to be buried or cremated, whether they wanted family to be present and whether they wished to remain at the home or go to hospital.

At the time of the inspection there was one person who was receiving end of life care. Their end of life care plan noted their dislike of noise or music, and their desire to maintain a high standard of personal grooming with a pain free death. This showed the service was committed to personalising the service to people at the end of their life.

The provider ensured there were suitable arrangements in place should a person die on Shabbat.

The provider had a complaints policy and we could see that they had dealt with complaints in a timely and appropriate manner in line with their policy. Relatives told us "Yes," they knew how to, but "We have not made a formal complaint." Another said, "I have raised a few minor concerns which have been dealt with." There were also numerous compliments from relatives, particularly following a person's passing, thanking the staff and the management team for providing good care to their family member.

Good

Is the service well-led?

Our findings

The provider has a vision and strategy to deliver care and support to the Jewish community. The provider states its core values as excellence, enabling, creative, inclusivity and integrity.

At the last inspection we found there was a breach of the regulations relating to the governance of the service. At this inspection we found there were significant improvements and the service was well-led.

The provider valued its managers and there were support systems to enable shared learning across the organisation. For example, registered managers met monthly to share best practice across the provider's services and undertake training. Minutes showed us there had been a recent presentation from a psychiatrist from the memory service in the management of older people and another organisation had given a presentation on dementia from an alternative perspective to increase staff knowledge and skills. There were also meetings for care managers within each service to increase their skills and knowledge and share best practice.

Sevice manager audits took place monthly looking at care plans, supervision, staff files and training. The registered manager and deputy manager followed up on actions and recorded when they were completed. Periodically the registered manager and deputy manager audited the service at night to ensure that quality at all times was of a good standard. Additional audits took place in relation to medicines and housekeeping. There were systems in place to record and review safeguarding events and accidents and incidents. Supervision and training were up to date and there were systems to ensure these took place and were up to date. The facilities management of the building was well organised and managed.

People were in general, positive about how the service was run. We were told "Every floor has a manager; it's a woman on mine" and "No I've got no worries about that (how the service is run)." People were also, in general positive about recommending the service to others. They told us "Yes" and "I think it is very good here" when asked if they could recommend the service to people.

The majority of relatives we spoke with were also positive about the service. They told us "I think it's very good and very well-run." Also, "I think it is brilliantly run." "I think it's very good and very well-run. In the main, they look after him very well and they're very attentive." Another said "We have recommended [the home] to three people two of whom ended up coming here. The third person would have as well only they died."

Some people and relatives were more guarded in their view and told us "Things could improve" and when asked if the service was well run said "To a degree."

The management of the service held regular relatives meetings to provide information about developments and gain the views of family members. For example, following the CQC inspection in January 2017 there was a relatives meeting held in March 2017 to gain the views of relatives; a number of issues were raised, for example problems with the keyworker system, records not being up to date and delays with toileting. A

document set out what the service would do to address these issues. We could see from minutes of the September 2017 relatives meeting that the service fed back on the actions taken to address the issues raised. These included the review of the key worker system, the implementation of the electronic care records to ensure care records were up to date and recording took place in real time, and the introduction of the team leader role to provide a more effective management structure on each floor. The service also produced a newsletter for relatives and people living at the service to keep people updated.

However, not all areas of concern highlighted had been resolved. For example, one issue raised in March 2017 was 'Staff ignore requests by residents to go to the toilet because they are too busy.' The action was for management to continue to train staff in fundamental standards whilst reviewing the time taken to deliver care.' We could see that staff meetings had discussed these issues and staffing levels had been increased, but we found from our discussion with some people that this remained an issue. The service could not evidence that they had checked back with residents that this issue had been resolved.

There had been two residents' meetings held in the last year at the service on each floor, in September 2017 and February 2018. A number of issues had been raised and discussed, for example, the use of agency staff and recruitment, laundry issues and opportunities to go out. People's experience of toileting had not been specifically addressed. The service was not feeding back to people at the service in the format of 'you said' 'we will do' or 'we did' as they were with relatives.

People gave us a variety of responses in relation to the residents meetings which included "There was only one; yes, it was good. I'm just waiting to see if they do the things" and "Yes they have them [resident's meetings]; complaints are aired and they do try to change things" to "Nobody does anything. So many people can't think or do for themselves, so who speaks up for them?"

We asked the registered manager how they got the views of people living at the service in relation to their experience of care. They told us that they asked people for their views as part of their audits; people were involved in care planning and at their annual review. In the future, the electronic care system would enable people to comment on care provided.

The provider did not currently have an effective system for gaining the views of people who lived at the service and then feeding back the actions they had taken to address issues raised. The registered manager told us they were aware the residents meetings were not always effective as not all people could attend or recall issues due to memory problems, and were considering how to take them forward.

We have made a recommendation earlier in the report that the provider develops formal systems to obtain regular feedback from people regarding their personal experience of care.

Care and nursing staff praised the management of the service and told us they felt very involved in how the service was run. One staff member told us "The manager encourages us not just to participate but to speak our minds." Another said, "The management treat us well, that is why I have stayed so long." There were regular staff meetings for both day and night staff at which key issues were discussed covering both best practice in caring and issues important to staff, for example, food available to them during their working day. Bank and regular agency staff had supervision and access to training and one bank staff member told us "The staff make me feel I am permanent." We were shown a leaflet for staff that explained the role of CQC and what an inspection involved and the staff role in this. This was an example of the organisation helping staff to understand the requirements of their job and their role in CQC inspections.

We could see the provider had a recruitment strategy across the organisation which was broad ranging in its

scope. The provider was focusing on recruiting and retaining staff as they understood the importance of continuity of care for people. This was evidenced by a recent award they received in relation to a recruitment drive in which they promoted Jewish Care as a dynamic organisation to work for, which showcased the diversity of roles within the organisation, but also highlighted the wide variety of backgrounds that employees had.

Once employed, staff told us they felt supported to progress in their role. One staff member told us, "I want to be a nurse and the management are helping me." Initiatives like these helped staff feel valued and committed to the service.

The provider had plans to make significant improvements to the garden area in 2018.