Sussex Tikvah

Rachel Mazzier 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

The inspection was announced and took place on 12 December 2018. The inspection took place on 19 May when it was rated as 'Good.'

Rachel Mazzier House is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides accommodation for up to 6 people with a learning disability or autistic spectrum disorder. On the day of our inspection there were four people living at the home. The home is converted from a residential house in a suburb of Brighton. The home has six single bedrooms. There was a communal lounge and a dining room plus bathrooms and toilets. The home provides a service to people from the Jewish and wider community.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Staff had a good awareness of the of the importance of protecting people and what to do if they considered people were not being treated appropriately. Risks were assessed and there were procedures to mitigate these. Medicines were safely managed. Sufficient numbers of staff were provided to meet people's needs. Checks were made on the suitability of new staff to work in a care setting. The service was clean and hygienic. Reviews of accidents and incidents took place.

Care staff were supported well and had access to a range of training courses including in the care of people with a learning disability. Staff had a good awareness of the cultural needs of people.

People's nutritional needs were assessed and people were supported to choose their own meals. Health care needs were assessed and the provider made referrals to health services where this was needed.

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. The provider had a good knowledge of the Mental Capacity Act 2005 and made appropriate referrals to the local authority when people did not have capacity and whose freedom was restricted for their own safety.

Care staff treated people with dignity and respect. People were supported to make decisions about their

care and support which promoted their independence. Care staff had a good understanding of the need to ensure people's privacy was upheld and for promoting people's rights.

People's needs were assessed. Each person had care plans which reflected their needs, preferences and choices. People's communication needs were assessed and communication tools were used to involve people in decision making.

People were able to raise concerns with the staff and there was a complaints procedure was made available to people.

The service was well – led. There were systems to monitor the quality and safety of the service which involved seeking the views of people, their relatives and health and social care professionals.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Rachel Mazzier 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 December 2018 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we checked information that we held about the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke to two people who lived at the service. We also observed staff interacting with people. We spoke with two care staff and the registered manager.

We looked at the care plans and associated records for two people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and records of medicines.

Good

Is the service safe?

Our findings

Staff were trained in safeguarding procedures and had a good understanding of the need to protect people. Staff knew how to raise any concerns to the local authority safeguarding team. People said staff looked after them well. Procedures and checks were in place where people were supported with their finances.

Risks to people were assessed and arrangements were put in place to mitigate risks and to support people to be independent in a safe way. This included risks regarding the management of personal care, using the kitchen equipment, behaviours which may challenge others, the risk of falls and risks of not eating enough food. There were care plans on how to manage these risks, such as recognising and managing risks of behaviour to the person and other people and staff. People said the staff supported them to be independent in a safe way. For example, one person described how staff supported them to use public transport safely. Referrals were made to external health providers for more specialist assessment and guidance where needed such as the NHS Trust falls prevention team. Care records showed incidents, accidents and behaviour were monitored, recorded, reviewed and appropriate action taken when needed.

Checks were made by suitably qualified persons of equipment such as the fire safety equipment, fire alarms, electrical wiring and electrical appliances. Fire alarms and emergency lighting were checked and tested. Hot water was controlled by specialist mixer valves so people were not at risk of being scalded by hot water. First floor windows had restrictors so people could not fall or jump out. Where needed, people had a personal evacuation plan so staff knew how to support people to evacuate the premises in the event of an emergency. The staff were trained in fire safety. There were contingency plans in place in the event of a fire or need to evacuate the premises. Measures were in place regarding the risk of Legionnaire's disease.

The provider ensured there were sufficient numbers of staff to meet people's needs. The provider used an assessment tool to indicate the total number of staff hours needed to meet people's needs. There was at least one staff member on duty at all times and additional staff were provided when people's needs changed or when people attended activities in the community. There was an agreement with a local authority commissioner that one person could have additional funding to provide up to five hours staff input on a one to one basis when needed. Staff considered the staffing levels were sufficient to meet people's needs, although one staff member felt an additional staff member on duty would make it easier to support people with activities.

Checks were made that newly appointed staff were suitable to work in a care setting. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting.

Medicines were safely managed. Staff were trained in the handling and management of medicines. Records were kept when staff supported people to take their medicine. Medicines were safely stored.

Staff were trained in food hygiene and infection control. The service was clean and hygienic. People were involved in cleaning their rooms with staff support. Staff had access to disposable aprons and gloves to use

when supporting people for the purposes of infection control and prevention.

Good

Is the service effective?

Our findings

People told us the staff were helpful and effective. For example, one person said the staff were skilled in supporting them with a range of needs such as cooking and managing their finances.

A range of training courses were available for staff including training in recognised care practices for people with a learning disability, such as training in interventions where there may be physical contact with people. This training was accredited with the British Institute of Learning Disability (BILD). Equality and diversity training was provided to staff, who demonstrated their commitment to promoting people's rights to a good standard of care, to making choices and to promoting independence.

Training courses were provided for staff in personal safety, first aid, moving and handling and medicines procedures. Staff also completed nationally recognised qualifications in care such as the Diploma in Health and Social Care at various levels, including level five in leadership and management. Staff said they were supported to complete training courses. Staff received regular supervision and felt supported in their work. Staff said they worked well as a team.

Staff received an induction to prepare them for their job and this involved an assessment of their competency to work effectively and safely with people. The induction was the prime responsibility of one staff member who described the process of training each new staff member.

People's nutritional needs were assessed and care records highlighted when people were at risk of not eating enough and how the person should be supported. People's weight was monitored for any weight loss or gain. People confirmed they discussed and agreed the menu at the weekly house meetings, which confirmed choice in meals was provided. There were arrangements to ensure people's cultural needs regarding food and Jewish traditions were followed regarding food preparation and food types. Staff supported people to join in with the cooking of meals.

People's physical health needs were assessed and arrangements made to ensure health care checks were carried out. These included dental care, eye sight checks, health checks at the GP surgery and more specialist hospital assessments and treatment. People had a 'Health Passport' so information could accompany people to hospital so relevant details could be passed to hospital staff. The provider worked with other organisations to deliver effective care. This included local authority social services teams and specialist health care services.

The service is a residential property and is homely. Each person had their own room and there were a number of communal areas which people used, such as the kitchen, lounge and dining room. There was a garden for people to use in the summer. Bedrooms were personalised with people's art work, books, DVDs and other belongings important to them. The building was suitable for people in terms of accessibility and the registered manager was aware that changes may need to be made to the premises as people get older and their mobility needs change.

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 with appropriate legal authority. We checked whether the service was working within the principles of the MCA and whether the correct action was taken where people's liberty was restricted. Referrals were made to the local authority when people did not have capacity to consent to their care and treatment and when their liberty needed to be restricted for their own safety. Care records showed people were consulted and involved in decisions about their care. People confirmed they were involved in decisions about their care.

Good

Is the service caring?

Our findings

People were treated with respect and kindness, which was confirmed by people. For example, one person said, "I like all the staff. They are like family. Everyone is nice. It is like a home." Another person said, "It's the best home of the lot. The staff are terrific. When you feel upset they are always there to help you."

Care plans and care provision was person centred, meaning they were individualised to reflect each person's needs and preferences. Details regarding support to people with emotions and behaviours was recorded in a positive support plan. For example, one person's care plans included details under headings such as, 'What happens when I get upset,' and, 'What I want staff to do when I am upset.' People's cultural and religious customs were promoted by the staff team and registered manager who had a good awareness of Jewish traditions, customs and observances which were catered for. Arrangements were made for a Rabbi to visit people at the service.

Staff demonstrated they had values of respect and of treating people with warmth and consideration. For example, staff said they treated people as they would a family member, involving people in all aspects of running the service. Staff also demonstrated they had values of treating people equally irrespective of any disability. Staff also confirmed the staff team was caring.

People were consulted and involved in any decisions about their care and support. There was evidence in care plans to show care was personalised and person centred to reflect preferences. People told us they were able to make choices in a number of different ways, such as in how they spent their time and choosing their food. People were also supported to have access to advocacy services so their views could be represented.

People were supported to be independent and to develop independent living skills such as in accessing the community and cooking. People's privacy was promoted. Each person had their own room, which they said the enjoyed using. We observed staff assisted people discreetly when supporting someone who needed to be monitored when they carried out their own personal care.

Good

Is the service responsive?

Our findings

People received personalised care which was responsive to their needs. People told us their needs and preferences, as well as their cultural needs, were met at the service. For example, one person said, "This is a Jewish household. We have kosher food. I'm very happy here." Another person said, "This is a really good home for me. The staff always support me."

People's needs were assessed and there were care plans to show how these needs were met. These covered a range of personal care needs, such as personal care, health, well-being, leisure, religion and emotional needs. Guidance was recorded for staff on meeting these needs and what staff and the person needed to do. The care plans incorporated people's preferences with details under headings such as, 'Things I like. Things I like doing. Things I expect from staff.' People confirmed they could express their views about their care and support. Staff used a person-centred planning questionnaire and person-centred feedback form to gain people's views about their needs and preferences. Care records were checked and reviewed on a regular basis.

People were supported to attend a variety of community based social and recreational activities. One person told us they attended a music and language lessons, adding, "I have a full and varied life." Another person said they had friends to visit and that they enjoyed attending a local day centre. One person said they enjoyed cooking with staff who had helped them develop cooking skills. People also attended art and creative classes and people said they enjoyed this; art work completed by people was displayed in the home. Staff said they supported people to develop their independence and involved people in all aspects of the running of the service so people could "reach their potential."

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. We found numerous examples of how the service was meeting the AIS, which aided communication between staff and people. Each person's communication needs were assessed. Pictorial diagrams were used to communicate with people, such as photograph displays of the staff on duty. Care plans also used pictorial representations to help people understand what was written.

The complaints procedure was displayed in the hall. People said they knew what to do if they had a concern and that there were a number of ways they could do this, such as the weekly house meetings or speaking to the registered manager. The provider stated there had been one complaint in the 12 months prior to the inspection. This was still being addressed at the time of the inspection. The provider confirmed correspondence was sent to the complainant acknowledging receipt of the complaint which was being investigated. The registered manager stated the complainant would be responded to in full once the complaint process was concluded.

Good

Is the service well-led?

Our findings

The service was well-led with a strategy to deliver person centred care and support to people. Staff had values of promoting person centred care where people could develop their independence in a homely, family environment. The provider placed people at the centre of its service provision including people's religious and cultural needs. People told us they considered the service was well-led. For example, one person said of the registered manager, "Joanne is a very effective and efficient manager."

Staff were supported to develop their skills and knowledge. Staff performance was monitored by direct observation, supervision and appraisal. There was a culture of openness at the service, such as staff and people being able to raise issues. Staff said they felt supported and were able to raise any queries or concerns with the provider. Staff meetings took place and staff said they felt involved in decision making.

The service had a registered manager. 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 system of delegation and line management with senior staff whose roe involved elements of supervision of other staff. Twenty-four-hour management support was available to staff.

A number of systems and processes were used to audit and check the quality of the service. These included regular checks on the health and safety of the premises, checks on finances, staff training and evaluations of staff interactions with people. The provider was forward looking and there was a continuous improvement plan, which included action plans for changes to the service.

The views of people and relatives on the standard of care provided were obtained using a survey questionnaire. The feedback results were positive regarding the standard of care, approach of staff to their work with people, and, regarding communication. Feedback was also sought from health and social care professionals which was also positive. For example, one professional said the registered manager promoted people's rights to inclusion, self-respect, dignity and independence as well as giving people a sense of stability and well-being. People also told us they were able to express their views at the house meetings, which also involved them in decision making.

Records were well maintained. Staff training included data protection and the General Data Protection Regulation (GDPR), which was effective from 25 May 2018. The provider was aware of the need to protect information on both staff and people and the guidelines as set out in the General Data Protection Regulation (GDPR).

The staff worked well with other agencies to provide coordinated care to people. This included local health services and social services regarding arrangements for people receiving the right care and treatment.