Jewish Care

Hyman Fine 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

Hyman Fine House provides accommodation, personal and nursing care for up to 51 older people. Some people had illnesses or disabilities associated with old age such as limited mobility, physical frailty or lived with health problems such as heart disease, diabetes and strokes. Some people lived with dementia. There were 38 people living at the home at the time of our inspection. Accommodation is arranged over four floors and each person had their own bedroom. Each floor had lift access, making all areas of the home accessible to people.

Hyman Fine House is a large building in a residential area of Brighton, close to the sea, public transport, local amenities and shops. The service is owned by the charity, Jewish Care and is one of their homes in the United Kingdom.

The home had a registered manager. 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 home is run.

There was a focus on providing care and support that looked at the need of the person but also empowered their individuality and identity. The registered manager told us, "Getting to know individuals is key to good care". Considerable thought and energy created an environment that provided stimulation and interaction. The provider had worked to recruit over 30 volunteers. Staff told us how they actively worked against any risk of social isolation. One member of staff said, "The philosophy of [the management] and Jewish Care is that people are given freedom and purpose through therapeutic activity. Since your last inspection this idea has had time to be embedded. We have looked at how we fit into the wider community as a whole."

People commented they felt safe living at Hyman Fine House. People commented positively about the care, treatment and support received. One person said, "Yes, I feel safe here. It's the trademark of the home."

People we spoke with were complimentary about the caring nature of staff. People told us care staff were kind and compassionate. People were treated with respect when they received care. A health care professional told us, "There is respect for the individual residents and their families' wishes."

Care plans reflected people's assessed level of needs. Care was person specific and holistic. People with specific health problems had guidance in place for staff to deliver safe care. They had risk assessments that guided staff and promoted people's comfort in such areas as nutrition and the prevention of pressure damage.

The delivery of care met people's individual choice. Care plans gave information on people's likes, dislikes. People's changing health needs, such as changes to eating and drinking were reflected and therefore staff

were informed of important changes to care.

Information was available on people's life history and this fed into their care plan. This impacted positively on people's well-being.

The dining experience was a social and enjoyable experience for people. People were complimentary about food at Hyman Fine House. One person told us, "The meals are superb. The chef does cook traditional Jewish food." People were supported to eat and drink in a dignified manner.

Quality assurance systems were in place. The registered manager had a range of tools that supported them to ensure the quality of the service being provided.

Arrangements for the supervision and appraisal of staff were in place. Staff told us they felt supported and recognised the part that regular scheduled supervision played. A staff member said, "I feel secure and supported. I can go to my line manager if I have any problems. Outside of those times I receive supervision every six weeks."

People had access to appropriate healthcare professionals. Staff told us how they had regular contact with the GP if they had concerns about people's health. A healthcare professional said, "I do a regular weekly surgery at Hyman Fine House. I think the home is well run by the manager and senior staff. They provide a high standard of nursing and personal care to residents in the home."

People were protected by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Jewish Care had registration with the Nursing and Midwifery Council (NMC) that was up to date.

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

Hyman Fine House was safe.

Staff received training in how to safeguard people and were clear about how to respond to allegations of abuse.

The management of people's individual risk assessments to maintain their health, safety and well-being were in place.

The management, administration and storage of medicines was safe.

People's needs were taken into account when determining staffing levels.

There were enough suitably qualified and experienced staff to meet people's needs. Staff recruitment practices were safe.

Is the service effective?

Good

Hyman Fine House was effective.

Meal times offered a social dining experience.

Staff received ongoing professional development through regular supervisions.

Training that was specific to the needs of people had been undertaken.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Mental capacity assessments for people who had limited capacity were reflective of individual needs.

Is the service caring?

Good

Hyman Fine House was caring.

People and visitors were positive about the care received. This was supported by our observations.

Care focused on people's individual preferences and respect of their dignity.

Staff were kind, thoughtful and gave reassurance to the people they supported.

Is the service responsive?

Good

Hyman Fine House responded to people's needs and preferences

The service was devoted to getting to know the people they supported.

There was a focus on the importance of knowing peoples histories, likes and dislikes. There were strong and enduring community links.

The service delivered a high standard of personalised care that was embedded within staff practice.

People had access to a wide range of meaningful activities which were tailored to individual needs.

Is the service well-led?

Good

Hyman Fine House was well led.

The management team promoted a positive culture which demonstrated strong values and a person centred approach.

There were effective systems in place to assure quality.

Forums were in place to gain feedback from staff and people.

Feedback was regularly used to drive improvement.

Hyman Fine 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. The inspection checked 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 home and to provide a rating for the home under the Care Act 2014.

The inspection was carried out on 3 & 4 May 2016 and was unannounced. It was carried out by an inspector, an expert by experience and specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist adviser brought skills and experience in nursing. Their knowledge complemented the inspection and meant they could concentrate on specialist aspects of care provided by Hyman Fine House.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. It included information about notifications. Notifications are changes, events or incidents that the home must inform us about.

During the inspection we spent time with people who lived at the home. We spent time in the lounge, dining room and people's own rooms when we were invited to do so. We took time to observe how people and staff interacted.

We spoke with nine people and three of their relatives or visitors. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We gained the views of staff and spoke with the registered manager, deputy manager, service manager, nurse and four care workers. We also spoke with staff who worked in housekeeping, laundry, kitchen and maintenance.

We contacted selected stakeholders, including four health and social care professionals, the local authority and the local GP surgery to obtain their views about the care provided. They were happy for us to quote them in our report.

We looked at five care plans and four staff files and staff training records. We looked at records that related to how the home was managed that included quality monitoring documentation, records of medicine administration and documents relating to the maintenance of the environment.

The last inspection was carried out on 12 February 2014 and no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe. We received the following feedback, "Yes, I feel safe here. It's the trademark of the home" and "Oh yes, I feel safe. That's why I'm here."

People and their relatives all said that they felt safe and free from harm and would speak to staff if they were worried or unhappy about anything. This was borne out in our observations of people who were at ease and comfortable with staff. We saw people conversing and smiling with staff and looking relaxed and happy in their company. People were assisted to recognise abuse and take action themselves. The provider produced information cards detailing what to do if someone suspected abuse. The cards were in each person's bedroom. Staff were aware of their responsibilities in relation to keeping people safe. Staff were able to describe the different types of abuse and what action they would take if they suspected abuse had taken place. They told us about what safeguarding meant to them including the potential signs to look for and the different types of abuse that people might be subject to.

There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records showed that staff had received training, and refresher training, to ensure they understood what was expected of them. Care staff were able to describe the different types of abuse and what action they would take if they suspected any abuse had taken place. One care assistant told us, "If I saw any poor care I would report it to the nurse in charge, the team leader, the deputy manager or manager who would investigate it. If you don't report you are as bad as the person doing it."

There were enough trained and experienced staff to ensure people's individual needs were met and to ensure their safety. On the day of our inspection the nursing staff were supported by senior care staff (team leader) and care assistants. Ancillary staff included teams working in the kitchen, housekeeping and laundry. We observed that people in the communal areas of the home were appropriately supported during the day. We heard how one person, a holocaust survivor, developed significant additional mental health needs that exhibited as increased agitation and behaviours that challenge. Additional staff were provided to meet the additional need until a smaller, specialist dementia care placement could be found that safely met their needs.

Staff recruitment practices were thorough, people were only supported by staff who had been checked to ensure they were safe and suitable to work with them. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care and support. All potential employees were interviewed by the provider to ensure they were suitable for the role. All new staff were required to undergo a probationary period during which they received regular opportunities for practice supervision.

Staff were able to offer assistance to meet people's individual needs. Some people accessed call bells when they wanted the support of staff. We observed that staff answered these promptly. We looked at the record

of responses that was held electronically and saw that no one in the preceding three days had been left waiting for more than nine minutes before their bell was answered. People and their relatives told us that call bells were responded to promptly. One person said, "If there is [staff] sickness it's hard for them but they do work hard keeping up with the calls on their time." The registered manager told us, "I have regular conversations with the provider where we review the staffing levels. We talk with staff and listen to feedback about what feels like a reasonable staffing level. For instance, when the number of residents declined the staffing establishment stayed the same."

Staff said that they were busy but made time to give people the individual attention they needed and followed people's individual preference. One staff member said, "You can never have enough staff but I know we have more than other care homes. I've seen residents' needs increase as, for example, more people are diagnosed with dementia." Another member of staff told us, "People living here have big characters, they love talking, swapping stories and sometimes enjoying a good argument with each other. My job is to be there for them and while I don't get a massive amount of time I can usually find the moment to sit and chat." The home increased staffing to respond to the higher needs of people. The registered manager said, "We had a resident who needed end of life care. An additional member of staff sat with them constantly towards the end when they were close to passing."

The provider had managed risks to individuals' safety and welfare appropriately. People who had moved into the home had a full needs assessment as part of the transfer. Care plans ensured people were safe and assessments of, for example, risk from falls informed staff how to keep people safe. There were moving and handling assessments in place that held information on, for example, seated positions in an armchair or assistance to mobilise. Staff were able to tell us what safe support looked like for people.

Care plans contained risk assessments specific to health needs such as mobility, continence care, falls, nutrition, and pressure damage. They reflected changes to people's health. For example, risk assessments such as the waterlow score, were updated to reflect the changes to skin integrity. The waterlow score is an assessment tool that gives an estimated risk for the development of a pressure sore for the individual. The documentation and knowledge of wound care ensured that placed people received appropriate care.

Pressure relieving equipment was used as a preventative tool for people with reduced mobility and assessed as at risk. For example, pressure relieving mattresses were set according to people's individual weight to ensure the mattress provided the correct therapeutic support. The risk of pressure mattresses being incorrect is that it could cause pressure damage. People whose risk assessment stated they were at high risk of pressure damage were supported to change position with use of aids, where required.

We looked at people's food and fluid records. The care plans directed staff to monitor people's food and fluid intake when it had been identified the person was at risk from malnutrition or dehydration. Records provided the total amount of food and fluid taken over 24 hours to safely monitor how much they had eaten or drunk. Some people needed additional support and would not always ask for drinks or be able to consume a drink fully independently. Records identified that they received sufficient amounts to eat and drink. The registered nurse told us about the people who needed to be monitored in response to an identified need.

People were assessed for the risk of choking when eating. The speech and language therapy team were accessed to provide advice and support. Some people received a soft or fork mashable diet and additional support throughout mealtimes. Guidance from health professionals was followed which met the additional needs of people at risk of choking.

Accidents and incidents were documented when they occurred. On the day of our inspection one person had bruising. Supporting documentation identified when the injury was first reported and the accident that surrounded the circumstances as known. Daily notes showed what action was taken. The registered manager had put preventative measures in place to prevent a re-occurrence by taking away learning from the incident.

There were systems in place to manage medicines safely. Medicine administration record (MAR) charts clearly stated the medicines people had been prescribed and when they should be taken. The MAR charts were up to date, completed fully and signed by staff. We observed staff when they gave out medicines. We saw medicines were given to people individually, the trolley was closed and locked each time medicines were removed. A nurse told us the home had recently introduced a coloured tabard for the member of staff with responsibility for administering medicines to wear. It indicated to other staff that they should not be disturbed. Staff signed the MAR only when people had taken the medicine. Medicines were kept in locked trolleys, which were kept secure. Staff followed the home's medicine policy with regard to medicines given 'as required' (PRN), such as paracetamol.

People were protected by robust infection control measures. Staff wore freshly laundered uniforms. They used personal protective items such as aprons and gloves which they were seen to change regularly reducing the potential for cross infection between the staff member and other people being supported.

Good

Is the service effective?

Our findings

People spoke positively about the home. Comments included, "As far as I'm concerned, they [staff] do their work well" and "The doctor visits once a week and you can see them if you are not well. They organise the chiropodist, dentist or whatever you need."

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. Staff were aware of their responsibilities under the MCA. They were able to tell us about the principles of the Act. For example, staff told us most people were able to consent to personal care and treatment, such as washing and dressing. They were able to tell us that the starting point when considering mental capacity was to presume capacity and that if someone lacked capacity this must be considered on a decision specific basis. Staff told us that people had the right to make what may be considered "unwise decisions" if they had the capacity. For example, staff identified that people exercised a positive choice to smoke even when they were well aware of the negative health implications as a result. 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, hospitals and in supported living settings are called the Deprivation of Liberty Safeguards (DoLS). The registered manager informed us that several people were subject to a DoLS with decisions following referral outstanding in some cases.

Staff attended training in DoLS as part of the MCA framework. Staff explained the purpose of DoLS was to ensure a person, in this case living in a care home, was only deprived of their liberty in a safe and appropriate way. This was only done when it was in the best interest of the person, and had been agreed by relatives, health and social care professionals and there was no other way of safely supporting them. Staff were aware that the keypad controlled front door, which prevents people entering and leaving the home, was a form of restraint and applications had been made to the local authority under DoLS about this.

Mealtimes were a shared experience and enjoyable regular event for people. It was a time that many people looked forward to. One person told us, "The meals are superb. The chef does cook traditional Jewish food and it's a kosher kitchen." People were offered the choice of eating in the dining room or in their room. People were offered a choice for their meal. A person said, "I'm a fussy eater and they will do something else if I don't fancy what's on the menu." Condiments such as salt and pepper and were available or offered. People could consult the menu available on every table or they discussed the choices with care or kitchen staff. There were staff available to assist or support. We noted the comment from one person who said, "Kitchen staff are marvellous and can't do enough to help." They engaged people with the options as part of the hum of conversation. People's food was discretely cut up by staff when assistance was asked for or when staff noted that a person maybe struggling with their meal. Meals were presented to people with a kind word and acknowledgement of the choice made. Some staff chose to eat a meal with people, further reinforcing the shared positive experience.

Staff ensured that people received suitable and nutritious food and hydration which was adequate to sustain life and good health. Some people appeared to eat little of their meal and in these cases staff members noted the response to the food and made sensitive enquiries about whether they liked the food or whether an alternative may be preferred. There was a record kept for those people who had diminished appetite and were at risk of not maintaining a nutritious diet. Weight records identified that there were four people who were consistently losing weight. We viewed the weight records. They stated what action was taken, including referral to the GP. For example, fortified food was offered as part of the action plan for the people at risk. Though we noted that only three people's names were on the list provided for reference to the kitchen. Our enquiries confirmed that the individual was receiving the appropriate fortified diet. Those people who ate in their rooms were checked in with by staff or for those that required additional support, had one to one care.

Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. The registered manager kept an up-to-date index of completed training and due dates for refresher training. Staff understood how good training provided them with the tools required to provide effective care. For example, staff understanding of living with dementia was gained from training in this key area. This was observed by the quality of positive interaction seen when supporting people and effectively managing some behaviours that challenged. One member of staff said, "We get a lot of training." A carer told us that they received the providers support to commence the Health and Social Care course at level three and that other staff were encouraged to aim for qualifications in care.

We looked at training records. The provider supported a range of training provided in-house and through external facilitators, through e-learning courses completed online and face to face training. Training records indicated that essential training in for example; MCA, safeguarding, health and safety, dementia and end of life care were completed. Jewish Care offered some specific training that reflected the cultural background of people. For example, all staff undertook Jewish festival and cultural awareness updates that reflected the diversity of staffs own backgrounds and need to learn about the cultural heritage of people they cared for. Additionally, some staff had undertaken holocaust survivor support that began to equip them to meet the needs of a very unique group of people.

The registered manager ensured staff received appropriate training, professional development and staff supervision to meet the needs of the people they cared for. Staff supervision was up to date. Supervision helped staff to address issues of professional practice and identify gaps in their knowledge that could be met, if necessary by additional training. Staff told us they felt supported and recognised the part that regular scheduled supervision played. Staff said, "I feel secure and supported. I can go to my line manager if I have any problems. Outside of those times I receive supervision every six weeks."

People received effective on-going healthcare support from external health professionals. People commented they regularly saw the GP, chiropodist and optician and visiting relatives felt staff were effective in responding to people's changing needs. A health care professional told us, "I do a regular weekly surgery at Hyman Fine House. I think the home is well run by the manager and senior staff. They provide a high standard of nursing and personal care to residents in the home. There is respect for the individual residents and their families' wishes. They have recently been awarded Gold Standard Framework status for their advanced care planning and care of dying patients."

Good

Is the service caring?

Our findings

People were consistently well cared for, supported and listened to and this had a positive effect on people's individual wellbeing. Staff focused on people's comfort so that people received appropriate care, treatment or support. We observed people who found it difficult to initiate social contact were given time and attention throughout the day. People and their visitors spoke positively of care staff and communication. Comments included, "The staff are amazing. They are so patient with the 'awkward' residents" and "They are good to [my relative] and to me. They allow me to bring the dog in".

Staff were people focused and treated everyone with the same respect, kindness and compassion. Dignity was promoted for example, one person told us, "They automatically shut my door and draw curtains when dealing with me." People who required it, were assisted to eat with the necessary support. We undertook a SOFI over lunchtime that confirmed staff interacted with people in a way that was respectful and considered their dignity. Staff talked with people, addressed them by their preferred name and followed practice that was caring and supported the value of dignity. People's dignity was also promoted in the communal areas when they were supported to mobilise. One person's legs and underwear was inadvertently shown when they were helped to move from their seat. As soon as the event was noticed staff offered privacy and gently offered reassurance to the person that they were looking after the individual's privacy and protecting their dignity.

We saw a person who showed signs of confusion and distress when they were approached by staff. They refused the personal care that was offered. Staff considered the persons reaction and continued to reassure the person with a calm and gentle approach that acknowledged their concerns and reality. They waited to gain the individuals trust and consent before they proceeded to provide the care that the person needed. Staff knew the person and were able to provide a person centred rationale for their approach to this individuals care.

People were supported to be independent and make day to day decisions. We observed that people were offered choices. Staff told us they were encouraged to consider how to maximise the choices available to people. For example, as part of their morning duties one carer told us, "I'll get different clothes out and show them the choices open to them." At mealtimes people decided when and where they wanted to eat. For example, staff involved people in making the choice about where they wanted to sit in the dining room to be most comfortable and to be with people of their choice. We noted an exchange in the dining room between a person living with dementia and a care worker. The person asked the member of staff repeatedly, "Who are you?" .The member of staff sat with the person during the meal and ensured they were at the same eye line level. They responded, telling the person their name and described to the person the care they were providing. They went on to acknowledge the persons reality and commented on their appearance. They said "[Persons preferred name] your hair is a bit wild today but that's how I know you like it," while gently reassuring them.

People were supported to make choices about how, where and what they did on a day to day basis. For some people the choice in the morning was to read the latest issue of the Jewish Chronicle newspaper.

Other people who tired more easily spent periods of time dozing in chairs or walking around the home. People's choices reflected conversations between care staff and people about what they wanted from life, such as their social needs and aspirations. One person had a seat of choice near the entrance to the home so they could, "Keep an eye on who was coming and going". It was explained that in their working life they had a similar function and this role acknowledged their previous status.

People were involved in the recruitment process. Staff employed at the home were interviewed by people as part of the application process. The exercise of choice and independence was also reflected in people's care plans and risk assessments. For example, one person lived with short term memory loss. Their condition meant that they did not always remember the front door code that was required to gain exit and entry. The person carried the code written down with them but sometimes mislaid it. Back up bits of paper with the number were discretely left in the persons pockets and topped up before they went out to help them maintain their independence.

The environment was both dementia friendly and homely. For example, people had their own professionally taken portrait picture displayed on their bedroom door. Some people chose to have no picture and others displayed an alternative image or sign. There was an abundance of sensory equipment to encourage mental stimulation or prompt reminiscence. For example, on the wall of the lounge a mirror was decorated with images of people and movie stars, including well known Jewish film stars from decades gone past. A dignity tree was erected in the entrance for the month of February. We were told that a dignity charter emerged from the work. The registered manager told us, "People completed a leaf and hung it on the tree. It was nice to have something visual and solid. It was the first thing that people saw when they came into the reception." Some of the responses recorded by people on tree included, 'Dignity to me means being able to make the choice of things I like doing so that I can maintain my self-respect,' and 'Dignity means nice presentation and looking nice'.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. A visitor said, "People are well looked after. I'm here regularly and always greeted like a friend." There was a synagogue within the building. The registered manager told us that it was used for Shabbat, the day of rest service, every week and people came from the local community to worship there. We learned that the adult grandchild of one person had arranged to have their wedding service at the synagogue.

Good

Is the service responsive?

Our findings

People and their relatives told us that the service was responsive to people's needs. Comments included, "The activities programme is good. Volunteers come in to entertain us. The activities relating to Passover were good." A relative said, "I do think they get the care they need. They cater for cultural needs. There is enough to do like baking and flower arranging. They [staff] do try to involve residents in activities." One relative told us about a concern surrounding a health issue that their relative had developed. They told us, "I raised this with the nurse and a referral was made to the doctor immediately and then followed up. They are absolutely responsive."

People's needs were assessed prior to them entering the home and this information was used to develop care plans. The registered manager told us, "Getting to know individuals is key to good care". Care plans contained details of people's likes, dislikes, preferences and how they wished support to be delivered. They held details of that person's history, how they liked to spend their time and what was important to them. For example, the home kept chickens and we saw how one person took great pleasure from looking after them, feeding them and collecting the eggs they laid every day. A member of staff said, "[Persons name] main joy at the moment is looking after the animals. So they feed the chickens and Sooty the cat. [Person] has always been helpful and caring and the role helps to settle them." The person collected the eggs and every day chose who was given them as a gift, be it a healthcare visitor or relative of someone at the home. This had a positive impact on the person because they were able to maintain interests after moving into the home.

People were engaged in activities that were meaningful to them. Considerable thought and energy created an environment that provided stimulation and interaction. There was an activities board displayed in the entrance hall and a daily list on a white-board showed any changes. For some people, items such as books and newspapers were important as a source of daily news. Others got pleasure from sensory items. One person cherished a doll, it provided a positive focus and sense of purpose to their day and rekindled memories for them. Staff reflected in their handover between shifts that the person had taken the doll with them on an activity, in this case attending a Jewish social group and the pleasure it was seen to bring them. People were supported to engage with activities that promoted their well-being and identity. Staff members provided activities and interactions that were based on people's individual likes and life history. For example, one person told us they had a passion for music, they said, "I'm a musician. There is enough to do but not everything suits everybody all the time. I choose what I do." We saw during the day that a member of staff produced a guitar and got people involved in an impromptu singalong and that people continued to hum and sing along to the tunes long after the instrument was put away again.

Throughout the home a programme of activities took place. These included quizzes, trips out, art classes, reminiscence group and coffee mornings. The management team told us, "We have a social care coordinator who works full time but we encourage volunteers to run activities and they bring their talents and skills." We heard that the home had worked to recruit over 30 volunteers. The registered manager said, "We have eight volunteers who help with the synagogue services and at Kiddish, the celebratory meal after synagogue." They told us about the 'Community Engagement and Volunteering Award' from The University of Brighton and Santander Universities. They recognised the ongoing program of student volunteering in the

home and the close links that they had developed with the university.

A befriending scheme sought to match people with others who shared interests. A member of staff said, "We identified that [person] didn't have many visitors. So we tried to pair them with a visitor who used to come and see their relative until they died and now they're doing activities which they otherwise wouldn't have tried. Their communication and outlook on life generally is turned around. They are in a better place altogether." A relative told us, "I know they have volunteers, who come in and play bingo, do cooking groups and so. It's all going on here." Among the plaudits received by the home we saw the following, '[Named member of staff] has been able to get [person] to join in an activity. The member of staff has been a miracle worker.'

On the afternoon of our visit a volunteer set up the dominoes group that ran every week. The management team commented that they tried to offer activities based on what people wanted, preferred and found meaningful. Staff members felt a key strength of the home was the focus on activities and people were empowered to say what activities they liked and didn't enjoy. The registered manager acknowledged that the home benefited enormously from the support of both the Jewish and wider community. They told us about the grant they received from a foundation established to help holocaust survivors. They said, "People from the home have established and sit on a committee to identify projects. For example, money has gone towards the chicken run, paying for a cooking group and having the participatory music groups supported by classical musicians."

Staff told us how they actively worked against any risk of social isolation. The registered manager told us, "We are fortunate, we have built up a massive group of creative volunteers and practitioners." We heard about how, following bereavements and the advance of dementia for others, only one person in the home played bridge where before there was a thriving group. A bridge group was contacted and invited to meet in the home. As a result, the person had once again been able to play their preferred game. The social care coordinator said, "The philosophy of [the management] and Jewish Care is that people are given freedom and purpose through therapeutic activity. Since your last inspection this idea has had time to be embedded. We have looked at how we fit into the wider community as a whole."

Staff interacted with people as they walked past, they used humour and, where it was appropriate, touch to engage with people. People responded to staff with smiles and chat and staff recognised the importance of supporting people to feel that they mattered. The environment was open and people were not restricted, if they wanted to be mobile and walk, they could do this safely both inside the home and in the garden. The home had an accessible secure garden area. The registered manager told us "The garden is an area people can access when they want."

A complaints procedure was in place and displayed in the reception area of the home. Most people told us they felt confident in raising any concerns or making a complaint but had not had cause to do so. The following response was typical, "I've never needed to make a complaint. I can't grumble or ask for anything more. I am well cared for." A relative told us, "I've never needed to complain. There are regular meetings for relatives. They do sort issues out." The home had received two complaints in 2016. Where complaints had been received, documentation confirmed they were investigated and feedback was given to the complainant. We were told by one person that they had gone to the office with an issue and felt it was handled appropriately.

Good

Is the service well-led?

Our findings

People, friends and family described the staff of the home to be approachable and helpful. People told us, "The manager and deputy are very friendly, their doors are always open." A relative said, "The management is approachable." Staff members spoke positively about working for the provider and commented they enjoyed working in a home where the ethos was on the delivery of person centred care. A staff member commented, "The management, and Jewish Care in the broader sense, I like how they work."

The culture and values of the provider and the home were embedded into every day care practice. Staff were able to tell us, "We get the support to be able to put the residents first." Staff we spoke with could provide an understanding of the vision of the home. From our observations of staff interactions with people it was clear the vision of the home were embedded into practice as care was person centred. Staff spoke positively of how they all worked together as a team. They said they supported each other and helped each other when they were busy. We were told, "It's a nice caring home." Another member of staff said, "We are a good team. When I am not working I help out by volunteering. We went on a little trip to the South Downs on the minibus. People love the activities and it makes for a fun team."

People, staff and visitors said that communication and leadership contributed to a pleasant atmosphere. The management team were visible and active in the home and felt that the morale of staff was good. A member of staff said, "I am grateful for all the support that I have received especially from [the deputy manager] and [registered manager]. I have felt that their doors were always open." We heard that poor practice would be challenged if it was witnessed by staff. Staff conceded there were constraints on their time, for example if there was sudden staff sickness, but felt that people received the care they wanted and required. A member of staff told us, "We do quite well. As a team we don't have a lot of sickness and we have a number of reliable people on the bank that we can ring. But the agency staff that we have used are regular and residents know them."

The registered manager told us their core values included having an open and transparent service, they were confident that the provider shared this value. They supported staff, visitors and the people who lived at Hyman Fine House to share their thoughts, concerns and ideas with them in order to enhance the service. Friends and relatives meetings were held to encourage people to be involved and raise ideas that could be implemented into practice. The provider used surveys to gain additional feedback from people. The last independent survey commissioned by the provider received 24 responses and provided overall performance ratings in such areas as staff, care and quality of life. In every area they scored above the average compared with other homes. We saw that where dissatisfaction with an aspect of the home was raised, for example, in the laundry service, the management sought to identify and address the issues. People and their relatives told us they liked to be involved and welcomed the opportunity to share their views. One visitor said, "They listen to views and try to carry out resident's wishes." Another said, "We have seen some positive changes."

We spoke with staff about how information was shared. They told us they were given updates daily through daily staff handovers and through regular team meetings. Handovers considered physical, social and emotional presentation of each person. Where there were concerns, for example if a person had not been

drinking and eating enough, or there was a physical response to an infection, their needs were discussed. Staff thought their suggestions to improve care were acknowledged and in this way felt listened to. A staff member said, "We are involved in improvements, the training and supervision are helpful and I feel listened too."

The registered manager had a range of tools that supported them to ensure the quality of the service being provided. This included a robust assessment and care planning system and regular reviews of people's care and treatment through handovers and supervision for staff. The home has achieved the commended status of the Gold Standard Framework (GSF) Award. The GSF provides structured guidance and training to those providing end of life care. It ensures better lives for people through high quality standards of care. Incidents and accidents were recorded, analysed and acted upon. All assessments and care plans were signed off by the registered manager or their deputy that provided for clear oversight of the care and treatment delivered. Audits of areas of the service took place. It included a monthly audit of medicine management. Risk assessments for the service were also regularly reviewed. The provider also audited the service and on the second day of our inspection we saw a provider led audit of health and safety.

The registered manager fostered links with key stakeholders. For example, the care home in reach team commented, "We have done a series of workshops in the home on dementia, including dementia awareness, behavioural and psychological symptoms of dementia, dementia and medication, meaningful activities and dementia and personal care… The home has been keen for our input and we have found the staff welcoming." They also attended and were active contributors to the local authority care managers forum.