Jewish Care

Rubens 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 22, 23 and 28 March 2018 and was unannounced. At the last inspection on 24 and 27 January 2017 we found the service was in breach of six regulations as stipulated by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that people using the service were insufficiently protected by the service's procedures to ensure that all decisions were made in their best interests within the requirements of the Mental Capacity Act 2005. The care and treatment delivered did not always meet people's needs and reflect their preferences. Risks to people's health and safety had not been appropriately assessed and the service was not doing all that is reasonably practicable to mitigate any such risks which included the proper and safe management of medicines. The nutritional and hydration needs of people were not always met. Sufficient numbers of staff were not always deployed to meet people's needs effectively. The service failed to effectively operate systems to: assess, monitor and improve the quality and safety of the services provided.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, effective, caring, responsive and well-led to at least good. During this inspection we found that the service had made appropriate improvements to the issues that we identified and how they planned to ensure sustainability of these improvements for the future.

Rubens House is a 'care home'. 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.

Rubens House accommodates up to 46 people in one purpose built building. Rubens House is operated and run by Jewish Care, a voluntary organisation and supports people from the Jewish community. Within the building there are three floors, each of which has separate adapted facilities. All three floors specialise in providing care and support to people living with dementia and physical health needs. At the time of this inspection there were 32 people using the service.

At the last inspection the provider had transferred an experienced manager from one of their other locations. This manager had become the registered manager for Rubens House. 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.

People and relatives told us that they were safe living at Rubens House and that care staff ensured their safety at all times. Care staff demonstrated a good understanding of how to keep people safe and how to protect them from risk of abuse or harm.

Each person's individual risks associated with their health and care needs had been identified and clear guidance was available for staff on how to reduce and mitigate the known risks to ensure people's safety.

The service had policies and procedures in place to ensure the safe management and administration of medicines. Issues noted at the last inspection had been addressed.

Robust recruitment processes were in place to ensure only staff assessed as safe to work with vulnerable people were recruited. We observed there to be sufficient staff available to support people with their needs. Staff did not seem to be rushed and people's needs were met appropriately. The service manager used a level of need assessment tool to ensure that appropriate staffing levels were maintained to ensure people's needs were safely met.

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.

Care plans contained appropriate documentation confirming consent to care had been obtained and where people lacked capacity, best interest decisions had been made and documented in partnership with the relevant involved individuals. Care staff were clearly able to explain their understanding of the MCA and DoLS and how this impacted on the care and support that they delivered.

People and relatives told us that they enjoyed the food at Rubens House. We saw plenty of drinks and snacks around the home that were available to people as and when they so desired. Where people were noted to have specific risks associated with their nutrition and hydration these had been clearly documented and appropriate measures had been implemented to monitor this.

Since the last inspection significant refurbishment work had been carried out to improve the environment of the home in order to make it more accessible and dementia friendly.

Records seen confirmed that staff received regular supervisions and annual appraisals as well as regular training to enable them to deliver safe and effective care.

We observed positive and caring relationships that people had developed with other people living at the home and with the entire staff team at the home. Issues noted with the use of agency staff had been addressed with the use of regular, known agency staff that regularly worked at the home.

Care plans were person centred and detailed. The provider was in the process of transferring all care plans on to an electronic care plan but this piece of work was being completed on a phased basis so as to minimise disruption. Detailed work had been completed around people's life histories called 'Remarkable Lives.'

As part of the electronic care planning system the service had already begun to record all daily living activities and monitoring onto the care plan. This included daily recording, food and fluid monitoring and activities participation. The electronic care plan was a live document that ensured entries of relevance were made at any time with reminders where a time lapse in recording had been noted.

Improved systems were in place to monitor and check the quality of care provided. We received consistently positive feedback from people, relatives and staff regarding the management structure in place, the support they received and the improvements that had been made.

The senior management team were always accessible to people, relatives and staff who spoke positively about them and felt confident about raising concerns.

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 were safe living at Rubens House. Appropriate systems and processes were in place which protected people from abuse and harm.

The service had robust processes in place to ensure the safe management and administration of medicines.

We observed appropriate staffing levels in place which safely met the needs of people.

Safe recruitment processes were followed to ensure only staff assessed as safe to work with vulnerable people were recruited.

All accidents and incidents were clearly documented with details of how the service reflected and learnt from each incident in order to prevent future re-occurrences.

Appropriate guidance and equipment was provided to all staff to ensure people were protected by the prevention and control of infection.

Is the service effective?

Good

The service was effective. People's needs and choices were comprehensively assessed and documented to ensure people received the appropriate care and support that they required.

Care staff were supported to effectively carry out their role and develop through training, regular supervisions and annual appraisals.

People were appropriately supported to drink and eat in order to maintain a healthy lifestyle.

Care staff understood and provided care and support according to the key principles of the Mental Capacity Act 2005.

The service ensured that they worked effectively within the home and across a variety of other health and social care organisations so that people received care and support through a holistic approach.

People had access to a variety of healthcare services to ensure their health and medical care needs were effectively met.

Is the service caring?

Good

The service was caring. We observed people had built positive and caring relationships with each other as well as the entire staff team within the home.

People were observed to be asked and involved in all day to day decisions. People were supported to maintain their independence where possible.

Care staff knew people well and had a good knowledge and understanding of their needs, wishes and choices.

People and relatives confirmed that staff always respected their privacy and dignity and we observed this to be the case.

Is the service responsive?

Good

The service was responsive. A variety of activities had been scheduled and delivered whilst the inspection was taking place. Activities were planned with consideration given to people's needs and abilities.

Care plans were detailed, person centred and responsive to people's needs. Care plans were reviewed regularly.

All complaints and feedback from people, relatives, visitors and health care professionals were recorded and responded to appropriately.

Is the service well-led?

Good

The service was well-led. The service had made significant improvements since the last inspection to ensure that people received safe, effective, caring and responsive care and support.

Improved systems were in place to monitor and check the quality of care provided.

The management team had introduced a variety of new initiatives to ensure people, relatives and staff received a positive experience of living and working at Rubens House.

There was a clear management structure in place and people and staff spoke positively of the senior management team and especially the improvements that had been made since the last

inspection.

People, relatives and staff were regularly involved and engaged in a variety of ways in order to obtain feedback about the quality of service provision as well as gain ideas and suggestions of where further improvements could be made.

Rubens House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22, 23 and 28 March 2018 and was unannounced.

This inspection was carried out by one inspector.

Prior to the inspection, we reviewed the information that we held about the service and the provider including notifications affecting the safety and well-being of people who used the service and safeguarding information received by us. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also looked at action plans that the provider had sent to us in March 2017, following the previous inspection.

We observed care and staff interaction with people in communal areas across the home, including medicines administration, breakfast and lunch in the dining room and a number of activity sessions that had been scheduled to take place. Some people could not inform us on their thoughts about the quality of the care at the home. This was because they could not always communicate with us verbally and we could not understand how they communicated due to their complex needs. Because of this we spent time observing interactions between people and the staff who were supporting them.

We looked at care records for nine people living at the service to see if they were up-to-date and reflective of the care which people received and ten people's medicine administration records. We also looked at personnel records for six members of staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including staffing rotas and quality assurance processes, to see how the service was run.

During the inspection, we obtained feedback from four people and eight relatives. We spoke with the

assistant director, the service manager, the registered manager, the care manager, three team leaders, four care staff, the chef, social care coordinator and a visiting rabbi.

Good

Is the service safe?

Our findings

At the last inspection in January 2017, people and relatives gave mixed feedback about how safe they felt especially due to staff shortages. At this inspection we found that the service had increased staffing levels to reflect and meet the needs and requirements of people appropriately. People and relatives told us that they felt safe and that there was always care staff available to meet their needs. Comments from people included, "I feel very safe here", "I do feel safe here, yes. The carers have such wonderful patience" and "Safe? Yes definitely." Relatives' feedback included, "I consider [relative] to be safe. There seem to be loads of staff around", "I feel the level of safety is good and there always seems to be enough staff around" and "Staffing levels have improved. Good as far as I can see."

Care staff also confirmed that staffing levels had improved over the last year and that even though the service continued to use agency staff, the service ensured that the agency that was commissioned only regularly sent the same care staff to the home for continuity. One member of care staff told us, "Staffing levels have improved and it is good. We have regular agency staff who get more familiar to the people and the work. We have enough staff."

Care staff at the last inspection had told us that they had concerns about staffing levels especially where people needed help with personal care and assistance during meal times. During this inspection we observed that people were supported in a timely manner in the mornings and at mealtimes and additional care staff support had been deployed at mealtimes which included a dining room co-ordinator who was responsible for ensuring people received a positive meal time experience. The service had assessed people's risk and dependency levels which were used towards determining staffing levels within the home. The tool assessed people's mobility, falls risks and their abilities to communicate and level of independence.

At the last inspection we found some concerns around the safe management and administration of medicines. The issues we found included gaps in recording, lack of knowledge and awareness of staff on how to monitor blood glucose levels and we saw one care staff administer medicines to a person in their hand and move on to another table without ensuring the person had taken the medicine. At this inspection we found that all areas of concern had been addressed and that medicines were being administered and managed safely.

People received their medicines as prescribed. We observed care staff allocated to administer medicines do so by involving the person, asking their consent and ensuring that they had taken their medicines. Medicines storage areas were noted to be clean and secure. Sufficient stock levels of medicines required within the home were held securely and where medicines needed to be disposed of, there were procedures in place to ensure this was done safely and appropriately.

Processes used for ordering people's monthly medicines to ensure that these were received on time were clear and understood by all staff involved. People received their medicines when they needed them

We looked at a sample of Medicine Administration Records (MAR) for ten people who used the service. There

were appropriate arrangements in place for recording the administration of medicines. These records were clear and fully completed. Records showed people were receiving their medicines when they needed them, there were no gaps on the MAR's and any reasons for not giving people their medicines were recorded.

Controlled drugs were stored and managed appropriately. There were no gaps in recording. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.

A number of people received medicines which were disguised in food or crushed. When medicines were being administered covertly to people we saw there were the appropriate agreements in place which had been signed by the GP, family and pharmacist.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, there were protocols in place which were tailored to the individual and provided guidance to staff on how these medicines were to be administered.

Where people's blood glucose levels required to be monitored as part of their medicine and health regime we saw records confirming this with guidance available to care staff on how and when blood glucose levels needed to be monitored.

Records showed that all qualified staff had completed medicines management training and that medicines competency assessments had been completed for those staff who administered medicines.

At the last inspection we found that people's risk assessments had several gaps and some had not been reviewed for more than two years. During this inspection we found that this issue had been addressed. Risks associated with people's health, medical and care needs had been clearly identified and assessed with details of the actions care staff were required to take. This included clear guidance to staff on how these risks affected people and the steps to take to monitor and support people in order to reduce or mitigate any risk identified. Identified risks and corresponding risk assessments covered eating and swallowing, falls, moving and handling, mobility, use of bed rails, diabetes, challenging behaviour and nutrition. Risk assessments were reviewed on a monthly basis or sooner where a change in a person's condition was identified.

The provider had safe recruitment processes in place to ensure staff recruited and employed were safe to work with vulnerable adults. A number of checks and assurances were required including Disclosure and Barring Service (DBS) criminal record checks, written references and, proof of identity. Records seen confirmed that these documents had been obtained and checked.

The provider had a safeguarding policy in place which gave information about the different types of abuse and staff members' roles and responsibilities when identifying and reporting suspected abuse. Staff were trained in safeguarding and whistleblowing and were able to explain the procedures. Staff knew signs of abuse and who to report to if witnessed or suspected any signs of abuse, neglect or poor care. One team leader told us, "In handovers we always tell staff if they see any cause for concern to report it to us. I would get the information, document and would report it to the manager." Another care staff explained, "If I had any concerns I would tell the manager or I can call the CQC."

We observed that the home was clean and free from malodours. The service followed their infection control policy in order to prevent and control of infection within the home. All staff received infection control training and had access to a variety of Personal Protective Equipment (PPE).

Records confirmed that all care staff had received food hygiene training. We saw that all food preparation and storage areas were clean and appropriate food hygiene procedures had been followed. This included cleaning schedules, specific food preparation areas for meat and vegetables, records of cooked food temperatures and food storage temperatures. On the day of the inspection the service had been inspected by the Food Safety Agency and had been awarded a five star rating.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting, gas and electrical safety, legionella, lifts and hoisting equipment were undertaken.

Personal Emergency Evacuation Plans (PEEPs) were in place and the provider had a clear contingency plan in place to help ensure people were kept safe in the event of a fire or other emergency. At the last inspection we found that the fire evacuation plan for the service had not been updated. At this inspection we found that fire evacuation plan had been updated.

Any accident or incident involving people or staff had been clearly documented with details of the incident and the actions taken which included appropriate referrals that had been made to relevant health care professionals. All incidents and accidents were completed online and reviewed by the registered manager with a record and confirmation of the actions taken and any learning outcomes. All accidents and incidents were also discussed at daily handover and reflection meetings so that any trends or patterns could be identified and to discuss any learning or improvements that could be made as a result to prevent any such future re-occurrences.

Good

Is the service effective?

Our findings

People and relatives confirmed that they were happy with the way care staff supported them and they felt re-assured that care staff knew their jobs well. One person told us, "The care is very good here. Whatever you need or want they [care staff] are there for you." Another person said, "Staff are brilliant and wonderful." Relatives comments included, "I know they [care staff] are skilled and trained", "I feel that they [care staff] are growing all the time. They are learning and growing and not static" and "They seem to be skilled and trained from what I can see."

At the last inspection care staff told us that not all agency staff were effective as they were not as committed to providing good care and did not always take instructions from the regular staff. However, during this inspection care staff confirmed that this had improved and that agency staff commissioned to work at the home were regular staff which enabled them to work more effectively and consistently. The registered manager told us and records confirmed that all agency staff listed to work at the home underwent an induction which covered a brief overview of the Jewish core values and health and safety. Agency staff were also provided with an overview of each of the people living at Rubens House which detailed their likes, dislikes, preferences and choices in relation to their meals. The agency also provided the home with a profile of the care staff which included all the training they had completed and the date of their criminal records check.

All care staff we spoke with confirmed that they had received an in-depth induction prior to them starting their employment with Jewish Care. This included the provider's policies and procedures and a session on the Jewish way of life. Care staff were also required to complete the Care Certificate. The Care Certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support. Care staff told us and records confirmed that they received training in a variety of topics which were refreshed on a regular basis. The registered manager had a training overview in place which outlined the date they had completed the training and when their refresher training was due.

Care staff's feedback about the training that they received was positive and care staff also told us that they were always encouraged to further develop their career within the service. Feedback from care staff included, "The training tells you exactly what to expect when you come into the job" and "They provide training and they help us to develop. I have worked alongside the team leader."

Care staff told us and records confirmed that they received regular supervision and an annual appraisal. We were told that they felt appropriately supported their role. Comments from staff included, "The manager is very supportive of us" and "I feel very supported in my role. Everyone is amazing."

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

At the last inspection we found that Information kept on people's plans on their ability and capacity to make decisions and how staff should support people to make decisions were not always accurate and at times contradictory. At this inspection we found that the service was meeting the requirements of the MCA 2005 and the Deprivation of Liberty Safeguards.

Where any person living at the home lacked capacity, we saw evidence that a mental capacity assessment had been completed and a Deprivation of Liberty Safeguard authorisation had been made to the local authority. Where authorisations had been granted, this was documented within the care plan including details of any conditions that had been set. The registered manager held an overview of each person who had been granted an authorisation and the date it was due to expire so that re-authorisation could be requested.

Records showed that where a person lacked capacity to make a specific decision, a multi-disciplinary approach had been taken in order to reach a decision which was in the person's best interest. Where risk assessments were in place in relation to the requirement of bed rails, we saw that a best interest decision had been made on behalf of the person, especially where they lacked capacity, and that the decision had been discussed with the relatives. Where a decision to administer covert medicines had been made we saw evidence that the family, GP and pharmacist had been involved in the decision making process. This had been appropriately recorded within the persons care plan. We also saw records of best interests decisions that had been made in relation to a where a 'do not resuscitate' authorisation was in place which had been clearly documented within the care plan. Where possible, people had signed their care plan consenting to the care and support that they received and where this was not possible relatives had signed the care plan on the person's behalf confirming their involvement in the planning and delivery of care for their relative.

Care staff clearly understood the principles of the MCA 2005 and were also on clear on ensuring that people were always involved and given choice in all decision making practises relating to their health and care needs. We observed care staff always seeking consent from people which included consent to support the person and consent when administering medicines. One care staff explained, "You cannot assume capacity. You can assess a person's capacity. You should engage and inform the person because sometimes through facial expressions and body language you can tell what the person wants."

At the last inspection we found that the service was not effectively meeting people's nutrition and hydration needs. Where people were noted to have significant risks associated with their nutrition and hydration these had not been recorded appropriately and where regular monitoring was required these had not been completed. People did not have appropriate access to drinks and were not offered drinks throughout the day. At this inspection we found that these issues had been addressed.

Where people had risks associated with their nutrition and hydration needs, risk assessments had been completed clearly identifying the risk and the measures in place to support the person with the risk. People's weights were monitored on a weekly basis. Where weight loss was noted or other areas of nutritional intake and output needed to be monitored, relevant charts had been completed such as food and fluid intake or bowel movements monitoring. Appropriate referrals had also been made to help ensure that people's nutritional needs were met. Records and guidance were available where people had been assessed as

requiring specialist assistance with their meals such as a pureed diet or thickening agents to be added to their meal or fluids.

We saw that people had access to a variety of drinks, snacks and fruit at any time in all areas of the home. People's experience of mealtimes was positive, they received their meals in a timely manner and care staff were available to support people with their meals where required. People were not left waiting for their meal. People were able to eat their meal wherever they chose which included areas such as the communal reception area or their own bedroom. The registered manage had introduced a new initiative where people were able to receive room service especially around breakfast time and could have their meal and medicines provided to them in their own room.

We observed people being offered a visual choice of meals, even though they had selected their choices on the previous day. We saw that where people, once served, did not want the meal that they had chosen, this was taken away and alternative options were offered.

Pureed meals were presented in an appetising way. Throughout the inspection we saw that meals looked appetising and people enjoyed the meal that they were offered. Everyone that we spoke to was highly complementary of the meals that were provided. Comments from people included, "Food is excellent, I can't fault the food", "Anything you like you get. If you don't like it they give you something else" and "The food is really good here." Feedback from relatives included, "My [relative] drinks all day long. There is always drinks available", "The food is fab. If I wanted to eat here I can" and "Food is fantastic. There are lots of choices. There are always drinks around and fruit and the staff encourage them."

The service carried out comprehensive pre-admission assessments to ensure that they understood and were able to meet people's health, care and medical needs. The assessment covered a number of areas including people's background, current circumstances, medical conditions, allergies and sociability. Assessments were completed with the person and in partnership with involved relatives and health care professionals. Where people were assessed to have specific health care needs which required the use of specialist equipment, the service ensured that the equipment was available in time for the person's admission. Care plans were reviewed on a monthly basis to ensure that they were current and reflective of the person's needs.

Documents seen confirmed that the service worked in a way which enabled effective communication and exchange of information about people within the service and across a variety of external organisations involved in the provision of health care and support. A live record of people's daily living health and social activities were recorded through an electronic care plan device. These were also discussed through daily handover and reflective practice meetings where the care staff team discussed any significant events that had been noted for people on the day any subsequent actions or monitoring that needed to take place to ensure the person received the appropriate care and support.

Records confirmed that people had access to a variety of health care services where specific needs or concerns had been identified. This included referrals to dieticians, speech and language therapists, physiotherapists, continence services and the mental health team. Records seen confirmed that referrals were made in a timely manner and people were seen by the appropriate professional where required. Details of the referral and the subsequent actions required had been clearly documented. The provider had also employed an in-house occupational therapist who was available to the homes to assess and monitor people's daily living needs and requirements.

Care plans recorded and detailed visits that people received from visiting health care professionals included

podiatrists, GP, chiropodists and opticians. People and relatives were happy with the support that they and their relative received in relation to their healthcare and were confident that any identified concerns would be addressed immediately.

Since the last inspection the home had undergone re-decoration and environmental improvements to ensure that it was suitable to meet people's needs. All areas of the home were accessible by people including the garden and outdoor spaces. Appropriate decoration and signage had been used around the home especially on the dementia unit to support people living with dementia in order to meet their needs and promote their independence.

Good

Is the service caring?

Our findings

People and relatives told us that they found the care staff very caring and were extremely happy with the care and support that they received overall at Rubens House. We observed that people and relatives had established positive and caring relationships not only with other people living at the home and their relatives but also with each and every staff member that worked at the home. Comments from people included, "Carers are caring. They are all very kind", "Carers are very good and they are caring. This is home. Even when I am out I can't wait to get back" and "I love the carers. They are just as nice today as they were four years ago" and "It's very nice, I like it here."

Relatives were equally complementary about the care at Rubens House and told us, "This home has been my saviour. This home is my family", "I've always had a laugh by the time I leave the home. The care is by far the best" and "The care is fantastic. The staff are definitely caring and caring towards the families. It is like a family."

We observed people had established positive and caring relationships with each other as well as with the entire staff team. People were seen to be happy and comfortable in their environment. We observed love, kindness, respect and compassion between people and staff. One relative told us, "I love the rapport that people have with care staff. I watch how they talk to my [relative] and other people. They give my [relative] a hug and hold her hand." We observed staff communication with people was warm and friendly, showing caring attitudes whether conversations were outwardly meaningful or not. Conversation and banter between people and care staff was seen to be friendly, jokey and informal. We observed laughter and warmth within the home throughout the inspection.

At the last inspection we observed some negative interactions between people and some agency staff working at the home at the time. During this inspection we did not see any negative interactions between people and staff including agency staff. We heard one person who had been supported by an agency staff member tell them, "God bless you. You are my darling."

People and relatives told us that care staff knew them and their relatives well and care was provided in a way which respected their choices, preferences and wishes. We saw that care staff knew the people they supported really well. One person told us, "Whatever you need or want they [care staff] are there for you. They don't take anything for granted." People were always consulted about the how they wished to be supported, the activities they wished to participate in and social outings. Relatives also confirmed that where possible they had been involved in their relatives care planning, annual reviews and were also kept updated by the service on a regular basis. One relative commented, "I feel as if I am part of the system. I am involved and they always involve me in the care planning process."

People and relatives confirmed that they were always treated with respect and that care staff always protected their privacy and dignity. Comments from people included, "They always knock on my door before entering" and "They [care staff] are very respectful in every way." Relatives told us, "They are respectful of [relatives] privacy and dignity. The nice thing is that staff are so warm towards [relative]" and

"Absolutely, her privacy and dignity is always maintained." Care staff demonstrated a clear of understanding on how they respected people's privacy and dignity. One care staff explained, "We talk to people, inform them of what we are doing, shut their door and make them inclusive of what we are doing."

Care staff understood the importance of promoting people's independence in order for them to continue to remain as independent as possible even whilst living at the home. One care staff told us, "We give people choice and we enable them to do as much as they can themselves. You have to be patient and encourage them." Care plans also recorded people's level of independence. One care plan recorded, '[Name of person] is doubly incontinent, however they are still able to verbally inform staff when they would like to be assisted to the toilet. They speak in Hebrew when they want to use the toilet.' We observed this person informing staff when they wanted to use the toilet and staff supported the person accordingly.

Good

Is the service responsive?

Our findings

At the last inspection we found that people's care plans were not person centred and did not capture their likes and dislikes, choices and preferences. Where care plans did record what people liked to do, this was not reflected in the care and support that we observed. We also found that activity records for certain people had not been fully completed and where they were completed people were recorded to be participating in the same activity of watching television on a daily basis. We also observed people had been left in their wheelchairs in the lounge unattended. During this inspection we observed that the provider had worked with the care staff team to improve these areas.

Care plans were found to be detailed and person centred and gave information about people's likes and dislikes, choices and preferences. The care staff team knew the people they supported and demonstrated knowledge an awareness of people's likes and dislikes and how they wish to be cared for. Care plans were reviewed and updated where required on a monthly basis.

The provider was transferring all care plans onto an electronic care plan system. The system was already fully operational for day to day recording and monitoring such as daily observations, food and fluid monitoring, activities participation and night checks. Recording was live and in the moment and where staff had not recorded information within a particular area the system was set up to alert the staff member with a warning bell that recording was incomplete within a particular timeframe. Where issues were recorded with someone's food and fluid, for example, this was highlighted by the system and the service was able to take immediate action such as making referrals to the relevant health care professional. The system could be monitored and reviewed at any time by member of the senior management team who also had the responsibility to confirm that warning alarms that had been set had been actioned. This meant that people received care and support which was responsive to their needs and requirements.

The registered manager had introduced a new initiative call 'Remarkable Lives'. This work involved the creation of each person's life history in a short story format. With the use of photos and information about the person, a life portrait had been created which enabled front life staff to gain a better understanding and appreciation for the people that they were caring for. Relatives we spoke with confirmed that the service had engaged with them to complete this piece of work. Care staff also confirmed that the life portraits were very useful as a topic of conversation when engaging with people on a one to one basis.

This new initiative also linked in with a new approach to dementia care that the service was implementing within the home. The 'Montessori' approach and principles focusses on the person living with dementia and their capabilities, capturing their interests and showing them respect. We saw care staff applying these principles throughout the inspection. As part of this approach everyone in the home including people, staff and visitor were asked to wear a name badge so that people could easily identify each other, staff and visitors. It was also positive to note that people had a choice to wear their name badge and did not have to if they chose not to. This approach was in the beginning stages of introduction but the core principles about ensuring that people were engaged in life, experienced a feeling of belonging and had a sense of purpose were very clear objectives for the service.

Activity boards detailing activities for the week were on display in a number of communal areas around the home. We saw these noted activities taking place during the inspection. Examples of activities that took place included flower arranging, language stimulation group, sing along, in-door gardening and one to one music therapy. We also observed examples of care staff interacting with people and initiating activities such as reading a newspaper, colouring and chatting with people. We also saw lots of items of interest and activity tools for people and their relatives to access at any time.

The home had also converted a communal lounge area into a sensory activity room which was used to deliver sensory sessions and music therapy for those people who were at the later stages of their dementia. On the second day of the inspection we saw one person participating in a one to one music therapy session as that person loved music. We saw the positive impact this had on the person's well-being. The social care co-ordinator was very passionate about her role and ensuring people were living a fulfilled life. They told us, "It's about finding out what's really important to them [people]."

The service used technology to support people with maintaining relationships, communication and accessing a variety of websites for entertainment purposes. A computer with internet access was available in the communal reception for people to use and we observed people using the computer to listen to music that they liked. People also had access to an electronic tablet to maintain communication through video calls with family living abroad.

Rubens House only supports people from the Jewish faith. With this in mind a wide range of religious and cultural activities including the observation of Shabbat took place on a weekly basis, Passover and other Jewish events were regularly observed and celebrated. For example on a weekly basis, to observe the Shabbat, people participated in the lighting of candles and eating a specially prepared meal together with relatives. People had access to a synagogue within the home where regular religious ceremonies were organised. visiting local rabbi visited the home on a weekly basis to support people with their religious, emotional, social and psychological needs where required. The rabbi told us, "I am here to add value to the residents' life. I like to put a smile on their face and provide them with emotional and spiritual support."

Care staff were able to describe to us what their understanding of the term 'person centred care' was. Explanations included, "This is always on the top of my agenda. It is always important to identify what is important to that person. We meet with the residents when they arrive to the home and we discuss their choices and wishes. It's about seeing the person as an individual."

End of life preferences and wishes were noted within people's care plans. Details included the person's wishes about their religious and cultural preferences on what they wanted to happen following their death. The visiting rabbi in partnership with the home was also very passionate about supporting people and their relatives when a person was receiving end of life care.

A complaints policy was available and processes were in place for receiving, handling and responding to comments and complaints. Information about how to make a complaint was on display in the home and all the people and relatives we spoke with told us that they felt able to complain if they needed to and were confident that their complaint would be dealt with appropriately. The service had only received two complaints since the last inspection which had been dealt with appropriately. The service also kept a 'grumbles book' where people or relatives had highlighted minor issues that needed to be addressed. We saw records of the actions taken to address people and relatives grumbles.

The home also kept records of all the compliments that they received. There were many compliments from families and relatives with examples of the good care that the service had provided.

Good

Is the service well-led?

Our findings

At the last inspection the service's audit process had not picked up the inconsistent recording of care plans, care delivery, gaps in risk assessments and MAR charts. The service overall lacked accurate, complete and contemporaneous records including records of the care and treatment provided and ineffective audits. During this inspection we found that the registered manager in partnership with the provider had implemented significant improvements to the quality of care and support people received.

People, relatives and visitors were all highly complementary of the registered manager and stated that since the registered manager's arrival at the home it had dramatically improved. Comments from relatives and visitors included, "I get on so well with [registered manager]. I can ask her anything", "[Registered manager] has implemented changes that's made the home even better" and "[Registered Manager] has made a change to the home. She has given the home a facelift. There is much more communication between herself and staff. She is available."

Care staff told us that they were supported through a variety of methods which included supervision, annual appraisals, team meetings, handover, reflective meetings, staff newsletters and the provider led staff forum. Care staff told us that they were encouraged to always actively participate and give ideas and suggestions. The provider had also set up a staff forum where representatives from each of the provider's locations came together to share information as well as give staff the opportunity to share ideas and issues that affect staff working for the provider. We spoke with the representative nominated for Rubens House who told us, "The forum is very effective. The agenda is normally about issues within each of the homes and how these can be improved. For example the provider had made the decision to charge staff for meals that they ate within the home. However, when we brought this as an issue to the staff forum the provider decided to reverse this."

Daily reflective handover meetings was another new initiative that had been introduced by the registered manager where the staff team came together to discuss staff and management experiences, observations, lessons learnt and actions to take forward. One care staff told us, "Reflective meetings are very good. We reflect on what we can do better. If we don't reflect we won't learn. We reflect on good things and bad things through this handover." Care staff were positive about the registered manager and the way in which they were supported. Comments included, "The manager is excellent because she is approachable" and "Good manager. Very supportive. You can call her at any time and she is always available."

Management oversight of the service had improved considerably. The registered manager in partnership with the care manager and team leaders completed a variety of checks and audits which reviewed care plans, medicine management, infection control, environment, health and safety, night time care and mealtime experiences. Where issues or concerns were found these were logged and details of actions taken were recorded. The registered manager and provider were very keen to ensure that though regular monitoring of the quality of care, the service could and would always continuously learn and improve.

In addition to these checks the service manager compiled an overview of the registered manager's findings from their checks and audits and then completed a comprehensive audit of the home. An action plan was

then developed based on the findings where the registered manager was required to detail the actions taken to make the improvements and by when.

The provider also held regular clinical governance meetings which were led by volunteers, directors and service managers to look at and analyse clinical issues across each of the provider's locations. These included review of complaints, accidents and incidents, hospital admissions, falls and use of anti-psychotic medicines. The meeting looked at any emerging themes and as a result improvement plans were discussed and cascaded through to each individual location for implementation.

Throughout the inspection we found that the registered manager and the senior management team were very committed to ensuring that the home provided a safe, effective, caring and responsive service and that the necessary and on-going improvements were made where required. During this inspection we found that senior managers were keen to engage with the inspection process and were aware improvements that had been previously identified. The registered manager told us, "My ethos is to give people the best life possible."

The provider had a clear vision to deliver high-quality care and support. Care staff were able to describe the values as set out by the provider which they were to follow in the day to day delivery of care. One staff member told us, "We all have the same vision, the welfare of the residents."

People and relatives were engaged and involved through a variety of ways to ensure that people's voices were heard and taken note of. The home produced regular newsletters as a way of sharing information within the home. One person had expressed a wish to set up a residents' forum led by people living at the home whereby people could share experiences and learn from each other. The registered manager took this idea forward and set up a 'Shared Voice' group. The first session was held in March 2018 and discussions around people's experiences, people's frustrations and the learning they could take forward. The next scheduled meeting would discuss how people felt on losing their independence. One person told us, "I do get involved because if I have anything to say I can say it. They [home] actually over involved me." In addition to these people were also regularly involved in quality assurance meetings and residents meetings.

Relatives and people's identified next of kin were also regularly involved and engaged through stakeholders meetings and quality assurance meetings. In addition an active friends group consisting of relatives and staff regularly met to discuss a variety of fundraising opportunities for the home in order to raise funds for activities and improvements within the home. Annuals satisfaction surveys were also sent out to people and relatives for completion to obtain their feedback about the quality of care that they and their relative received. Surveys covering 2017 had just recently been sent out for completion.

There was an open and transparent culture at the service. Relatives told us that the service always communicated with them about their relatives especially where significant incidents or accidents had occurred or where their relative had been taken ill. One relative told us, "They [home] always report to me about [relatives] progress and medically I am always involved." The registered manager also sent all relatives and involved next of kin details of significant updates occurring within the home that needed to be communicated. Relatives confirmed regularly receiving these updates.

The service worked in partnership with a variety of healthcare professionals and community organisations. We noted that that the service maintained positive links with healthcare professionals including the GP, physiotherapists, speech and language therapists and occupational therapists. The service also engaged with local theatrical and arts groups, local colleges, local mother and toddlers group, the local authority quality team, North London Hospice and local care homes in the area in order to ensure that people living at

Rubens House had access to a range of holistic services which supported their health and well-being.