Jewish Care

# Sidney Corob House

## Inspection report

122-126 Fortune Green Road
London
NW6 1DN

Date of inspection visit:
09 January 2017

Date of publication:
17 March 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

Sidney Corob House is a residential home providing care for up to 32 predominantly older people with enduring mental health conditions. The home caters specifically for people of the Jewish faith and there were 30 people living at the home at the time of this inspection.

This inspection was unannounced which meant the provider and staff did not know we were coming. The inspection took place on Monday 9 January 2017. Our previous comprehensive inspection on 8 December 2014 found that the service was compliant with all of the regulations we examined.

At the time of our inspection a manager was employed at the service. This person was awaiting their interview for registration with CQC. 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.

Risks assessments were in place and were regularly being reviewed. Risk assessments covered potential risks associated with people's day to day support needs, mental healthcare support, other healthcare conditions and any risks associated with daily living and other activities. Staff were aware of how to mitigate risks and instructions were clear about actions to be taken to reduce risks and how to respond if new risks emerged.

The service was diligent with carrying out staff background checks and recruitment procedures to ensure that staff were properly vetted before commencing work at the service.

Staff supervision and training was effective, staff reported that they were supported and staff appraisals did take place. The service provider showed us their plan to undertake the next round of staff appraisals from March 2017.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. The service was applying the principles of the MCA appropriately. Physical restrictions under DoLS were not applicable for anyone at the service at the time of this inspection.

We found that people's health care needs were assessed and the service had specific health care action plans to ensure that these assessments improved the range of potential health care needs of people. Care was planned and delivered in a consistent way and the service had regular contact with community mental health services and other health and social care professionals. Information and guidance was provided to staff about what was expected of them when supporting people and the procedures used at the service were clear.

The nine people using the service who spoke with us all said they were consulted and that their views were listened to. People were confident about approaching the manager and staff to talk about the things that they wished to and people felt that there was honesty in the way the service communicated with them.

The service complied with the provider's procedures to carry out regular audits of all aspects of the service. The provider carried out regular reviews of the service and sought people's feedback on how the service operated.

At this inspection we found that the service met all of the regulations we looked at.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe. People told us they felt safe and that there were always staff available to support them, which we confirmed by looking at the staff rota.

If any concerns were raised about people's safety the provider took these seriously and responded quickly to take any action that was needed.

Medicines were well managed and people were encouraged to keep and take their own medicines, if this was a safe option for them. If people needed staff support to take medicines this was managed well.

### Is the service effective?

Good

The service was effective. The provider recruited staff properly and safely and staff received regular training and supervision. Staff appraisals had happened and the manager provided the schedule for the next staff appraisals to commence from March 2017 onwards.

During our visit, we talked with staff about their understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards. They demonstrated that they had the necessary knowledge and awareness of both of these areas, and what they should do to respond to anyone who may be experiencing deterioration with their mental health condition.

### Is the service caring?

Good

The service was caring. Our observations of interactions between staff and the people was caring, respectful and showed that staff had a genuine interest about the welfare of the people they supported.

Staff told us of how they worked in a way that ensured that people's dignity and privacy were maintained. Staff told us that they viewed people as individuals first and not merely as a group of people who had experience of enduring mental health difficulties.

## Is the service responsive?

Good

The service was responsive. Care plans were updated at monthly intervals and were audited regularly to ensure information remained accurate and reflected each person's current support needs.

People we spoke with felt able to raise any concerns or issues about the service. We saw that people could raise anything they wanted to informally and this resulted in very few formal complaints being made as any action required was quickly taken in response. People felt assured they would be listened to and supported to resolve any concerns.

## Is the service well-led?

Good

The service was well led. People we spoke with said they felt the service was well-led, they liked the staff and manager. Staff told us that the provider and managers at the service communicated well and they felt a part of the team as a whole.

The service sought feedback from people using the service, families where appropriate and health and social care professionals. The service was able to demonstrate that it acted on this feedback through action taken to respond to any issues raised or suggestions for improvement.

# Sidney Corob House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced which meant the provider and staff did not know we were coming. The inspection took place on Monday 9 January 2017. The inspection team comprised of two inspectors and an expert by experience that had knowledge of using services for people with a mental health difficulty.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned a PIR and we took this into account when we made the judgements in this report. We also looked at notifications that we had received and any other information that we had received about the service.

During our inspection we spoke with nine people using the service, a Rabbi who visits the service regularly, six care staff, the manager and the area manager for the provider and deputy director for residential care services of Jewish Care. As part of this inspection we reviewed four people's care plans. We looked at the induction, training and supervision records for the staff team. We reviewed other records such as complaints information, quality monitoring and audit information and maintenance, safety and fire records.

Good

# Is the service safe?

## Our findings

When we spoke with people about how safe they felt we were told, "I do feel safe here, it is a very good place. If I had any concerns I would speak to my key worker or whoever is on duty at the time, probably someone I have a good rapport with and there's lots of them."

People also told us, "I feel very safe here. It is a very clean place, it is always being cleaned and the cleaners are very friendly too. There is a call alarm in my bedroom if I need to contact the staff in emergency at night or during the day. They come quick if I do press it," "The staff are very competent when it comes to medications and make sure they are not doing any mistakes you can tell they are very focused and double-checking things at medication time which is reassuring."

The staff at the service had access to the organisational policy and procedure for safeguarding vulnerable adults from abuse and a member of staff told us that they had been involved in updating this policy. They also had the contact details of the local authorities who had placed people as well as a copy of the procedures of the London Borough of Camden, which is the authority in which the service is located.

At the time of this inspection there were no safeguarding concerns. A concern that had arisen 2016 was responded to quickly and diligently by the provider and all actions to ensure people were safe, including investigation of the concern, were taken.

We looked at five staff recruitment files and noted the service had safe and effective systems in place to manage staff recruitment. The files contained the necessary documentation including references, proof of identity, criminal records checks and confirmation that the staff member was eligible to work in the UK. Any gaps in employment that were identified as part of the recruitment process was discussed with the staff member at the interview stage of the process.

The staff rota and deployment of staff around the home showed there were enough staff on duty to give people individual attention and meet their care and support needs. Support was offered to escort people to appointments if necessary and to attend meetings and other activities outside of the home. People using the service and staff told us they believed enough staff were available and additional staff were used if and when needed.

Records showed risks to people had been assessed when they first came to the service and were then regularly considered as a part of the monthly care plan evaluation. Up to date guidelines were in place for staff to follow. These covered areas such as keeping people safe and the signs to be aware of which may indicate a person's mental health was deteriorating. Risk assessments covered general common risks, for example going out unescorted or behavioural risks, as well as risk assessments tailored to each person's specific care and support needs. The provider's policy and guidelines for staff clearly stated that a no restraint risk management approach was used and it was reported that no restraint had ever been used as the de-escalation of incidents worked effectively.

Safe medicine management processes were in place. We looked at medicine records for 20 people and found that there were no gaps in recording. Each person's Medicine Administration Record (MAR) contained a front cover page which contained the person's name, date of birth, any allergies and a list of the person's medical conditions.

A consent form had also been completed which had been signed by the person or their relative where appropriate. This confirmed what support the person required, whether prompting or administration, or whether they were self-medicating.

A PRN (as required) protocol was available for each person which listed the PRN medicines that had been prescribed, the dosage and instructions for administration. Where people had been prescribed topical creams details of where creams were to be applied were recorded on a topical cream chart, kept on the person care plan in their room.

Each staff authorised to administer medicines received medicines training before being allowed to manage medicines. In addition the care manager completed three observational assessments which assessed competency. The manager also carried out quarterly spot checks and practise observations. These were also completed sooner if there were any concerns. Weekly medicine audits were completed by the shift leaders. The audits looked at any medicine errors, gaps in MAR'S, refusals and stock checks. The care manager then completed monthly audits for medicines.

Controlled drugs (CD) management was safe. Controlled drugs are those that have to be held securely and administered properly in accordance with the Misuse of Drugs Act 1971. We looked at four peoples CD stock levels and found these to be correct with two people signing when administration took place. Daily temperature checks were completed for the medicines room, fridge and medicines cupboard. Sharps boxes were available and collected by the local district nursing team for safe disposal. All unused, destroyed or refused medicines were returned on a monthly basis to the pharmacy. Details of all returned medicines were recorded in a returns book.

Two concerns we noted were that the service did not complete stock checks for all as required (PRN) medicines to ensure that there were suitable supplies of these medicines. Not all liquids and eye drops had the opening date recorded on the box so that staff would know when to stop using them after a 28 day period most especially for eye drops. We raised this immediately with the manager who said action would be taken and they asked a member of staff to look at these areas.

The provider had arrangements in place to deal with other common potential emergencies such as risk of fire or other environmental health and safety issues. Fire alarms were tested regularly and other safety checks, for example gas and electrical safety, were being carried out. We did note that a few hand gel sanitizers dispensers were empty around the home and were told that this would be attended to by domestic staff.

Good

# Is the service effective?

## Our findings

People using the service told us, "I have got a lot better since being here as I have been through a lot of depression but I have been supported throughout. This place has been very beneficial for me" and "I do have a copy of my care plan. It is very detailed from what I can remember, everything about me and what I am involved in within Jewish Care is within it."

People also told us, "The food here is really good. There is lots of choice available and I really appreciate the kitchen staff," "I am now able to go and come back in the community now. I couldn't do that before and it has been this place which has been really helpful in making that first step. The food here is really nice most of the time and I have been able to see a G.P when I have needed to."

Care staff that we spoke with confirmed that they received regular supervision. Records within staff files confirmed that staff members received regular supervision. Staff participated in appraisals. The manager provided us with a schedule of the next round of appraisals which was to commence from March 2017 onwards.

Supervisions that were held with staff covered areas including sickness, annual leave, training, people using the service, key working, medicines, activities, professional development and staff matters. The manager told us that since they had been in post a lot of work had been undertaken to build and improve working relationships between management and staff. This included group supervisions as well as individual supervisions. Staff we spoke with talked positively about the relationships with each other and the management as a whole team.

We looked at the training records for five care staff and we saw evidence that staff had undertaken induction training prior to commencing work with the provider. We also saw certificates confirming that they had attended training in areas such as moving and handling, medicines management, emergency first aid, food handling, care plans and fire procedures. The staff training matrix showed that refresher training was identified and timescales were listed for updating training whenever required. All staff we spoke with told us they felt supported by the provider in relation to their training and development.

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

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

Each of the staff we spoke with had a good knowledge of their responsibilities under the Mental Capacity Act

(MCA) 2005. Staff were also aware of the Deprivation of Liberty Safeguards (DoLS). Staff were able to tell us what this meant in terms of the day to day care and support for people. The service was aware of the need to carry out best interests referrals for assessments and this was carried out effectively as and when needed.

We observed care staff practices and people's mealtime experience at lunchtime. People went up to the service counter in the dining area and chose the meal they wanted from the two choices available. Most people were seen to be independent and required little support. People had access to all areas of the dining room and were able to make or get their own drinks which included making a cup of tea or coffee or getting water or juice. Menus were displayed in the dining area and were reflective of the food that was served. People knew what was on the menu and were also reminded at the counter and were given a choice.

People were supported by care staff where required. One person needed prompting and encouragement. The manager sat with the person with their own lunch and they ate together to ensure that the person was encouraged and supported. The chef knew the people well and knew about each person's individual likes and dislikes. One person was observed to thank the chef for the meal after they had finished.

People were supported to use general community healthcare services when they required. Each person was registered with a local GP (almost all used the same GP surgery), dentist and optician. Staff supported people to make and attend their appointments and these were planned for and people were supported by staff to attend these if required. Sidney Corob House ensured the information about people's current state of mental health was up to date and shared with mental health care professionals that were involved with each person's care. Each person had access, as and when required, to the professionals involved in supporting their mental health. Staff demonstrated a good knowledge of the people they supported and knew what signs to look for should a person's mental health condition begin to deteriorate. We did not receive any direct feedback from professionals about this. However, information on care planning records showed liaison and regular contact, not least where concerns about anyone's mental health had arisen.

Good

# Is the service caring?

## Our findings

People we spoke with told us of caring staff who were polite, kind and friendly. We were told that staff always knocked on doors before going into bedrooms. We observed various positive interactions between people living at Sidney Corob House and staff, particularly during lunchtime, where care staff showed patience and attention when supporting people to have their meal if they required help.

People told us that they had involvement in decisions about their care plan. The staff knew people well and had a good knowledge and understanding of their lifestyle preferences and needs. Bedrooms were personalised to a high standard. Every bedroom had a fridge and of the five bedrooms that we looked at, with people's permission, were decorated and dressed differently according to people's choice and wishes.

People told us, "The staff here treat us very well, I have had no issues with any of them. The staff always knock on the door before coming into my bedroom," "The staff here are okay, They are polite and speak to me with respect. I was involved in my care plan and things that I said to my key worker are in it." People also told us, "They are supportive and were particularly supportive when I was very unwell. I was battling (an illness) whilst being here and the staff really supported me through that difficult period" and "The staff here are 10 out of 10. They work very hard and they are very caring."

People's individual care plans included information about cultural and religious heritage, daily activities, communication and guidance about how personal care should be provided. We found that staff knew about people's Jewish heritage and had care plans which described what should be done to respect and involve people in practising their Jewish faith as they wished. The Rabbi who visited the home regularly said that they provided not only spiritual support and guidance but were a listening ear for everyone, whether living or working at the home. People were able to practice their religion openly and were supported to do so. Most of the people we spoke with attended a local synagogue and those who did not wish to solely out of personal choice had access to the services that the dedicated Rabbi provided on a weekly basis.

Some staff were not aware of anyone using the service at present who may be lesbian, gay, bisexual or transgendered. One member of staff we spoke with was able to tell us of their understanding of this, the other five were unclear. Although policy, procedure and training were in place for staff their responses suggested that the awareness of staff could helpfully be examined further.

People's independence was promoted. During our inspection some people were being assisted to engage in activities both inside and outside of the home and others were engaging in activities or past times independently. The area operations manager told us that the provider believed more development of external focused activities, not least for those who were unable to organise this independently had been recognised and this was being enhanced with further initiatives being taken. Sidney Corob House had a number of communal rooms for people to either have private time away from others or to engage in activities.

The social care coordinator and staff team was supporting people to become champions for different roles

within the home. For example the Garden Project. Jewishness in Sidney Corob and Holiday researcher. There were regular meetings where the 'advisors' were consulted and agreed plans were then put into place to utilise their skills.

The Social Care Coordinator had visited the local community centres to identify classes that may be of interest to people. We were told about the achievements of people who took part in classes at different venues and there monthly resident's meetings to discuss any changes or events happening at Sidney Corob House.

Two recently qualified art therapists visited the home to offer art sessions as well as visits from students, from as far as Hong Kong, who sang for and played Bingo with people. Another group of visitors had organised a sports day and a social action day where they painted two of the benches outside the home and helped some people put their hand prints on them.

We were also told about another group who undertook a media project and made films of people's life stories. They were planning to return, at people's request, to undertake further projects that people had requested.

The service had commenced training for staff in using the "Gold Standard Framework" for end of life care, which is a recognised standard for supporting people in this area. Advanced interests decisions were included in care plans where people had made their wishes known. These decisions included who they would like to be contacted in the event of sudden serious ill health or death, preferred Rabbi to be in attendance and place of burial. The service continued to give this important area significant attention as we had also found at previous inspections.

The manager informed us of plans to convert a vacant area within the home into an activity room which could be accessible by the community. The plan was for the community to be able to access exercise and activity sessions such as yoga, along with people using the service. The provider viewed this as a positive method of encouraging people to have contact with the local community and to build good local relationships, which had already begun and developments were continuing.

The Rabbi told us that, "We are really engaging with the community through the synagogue. People are opening up their homes to the residents for the Sabbath meal and it is mutually beneficial for everyone. I would go as far to say that it has helped the residents' mental health."

Good

# Is the service responsive?

## Our findings

We asked people if they had been involved in decisions about care planning and if they had seen their care plan, understood it and agreed with it. Everyone who commented on this was clear that they had been involved and we found that people had signed agreements confirming this.

The care plans we looked at covered personal, physical, social and emotional support needs. We found that care plans were updated at regular intervals and a monthly care plan evaluation system had been established in the middle of 2016. We did, however, raise an instance where this had not been completed each month and were told of the action being taken to update the outstanding evaluation. The keyworker for the person was doing this during our visit. The manager also audited the care plan and keyworker input every three months to ensure that information remained accurate and reflected each person's current support needs.

Records of care needs and interactions with people were kept each day. There was a checklist of things that the team leader for each shift needed to do to make sure planned events, appointments or other things happened which included reading the message book, checking the diary and petty cash. Daily handover records described events for each person and if there were any noted concerns for the preceding 24 hour period. These shift plans also stated the name of the staff allocated to each person and the names of staff administering medicines.

We were told about and viewed examples of how the service supported people to maintain important relationships, particularly with members of their family. Even if people's families lived some distance away or lived overseas the staff team made efforts to encourage and support continued contact wherever this was possible. This could be by telephone, letter or using the internet if people were unable to have direct personal contact.

In our conversations with people using the service there was a clear message that people felt no hesitation at all with approaching staff and raising anything they wished to.

One complaint had been received in 2016. Complaints were dealt with and managed appropriately. A record of the complaint, details of the investigation and actions taken were recorded. The on-site client care manager or registered manager also wrote to the complainant detailing the actions taken to learn from, and respond to, the complaint. The service encouraged people to complain especially where people observed bad practice within the home. Compliments were also recorded and copies received were kept centrally in the file. A response was also sent to the person acknowledging and thanking them for their compliment.

Good

# Is the service well-led?

## Our findings

People using the service told us, "The manager is around, it would be good she could be on more though, I think they have changed the times they are on recently, it was better before" and "The manager is approachable but can be very busy a lot of the time. She is always in meetings and doing paperwork and making sure the building is in working order." We passed these comments onto the manager for their information.

There was a clear management structure in place and staff were aware of their roles and responsibilities. Staff felt comfortable to approach the manager and told us so.

There was clear communication between the staff team and the managers of the service, and this was evident not least at the staff afternoon handover that we attended. Everyone present was given time to discuss the progress and actions for each person and to share their views. Staff were positive about the training, teamwork, and handover system.

The home's management team were required to submit regular monthly monitoring reports to the provider about the day to day operation of the service. The provider used this system as one of their key performance indicators, not just in terms of the service but senior staff's professional performance. Information is supplied monthly by the service to the provider based around key performance indicators which assess the operation of the service. These were sent to the service manager and assistant director and analysed quarterly by the provider. There were regular visits by representatives of the provider who were senior members of the provider's management team. As a result of these visits and the monitoring reports a response was then provided to the service about actions to be taken which was monitored.

Each quarter the provider held a clinical governance meeting which was designed to explore the performance of the service at the most senior provider management level. Oversight of the service was managed well and this was reflected not only by systems that were in place but also the action taken in response.

The service had undergone a period of management change earlier in 2016 and the provider felt that this was now stabilising and the service was in a position again to look at positive developments and improvements. Our conversations with people using the service and staff reflected the positive view that people had about the changes and developments.

Surveys were carried out centrally by the service provider every six months. We looked at the most recently published surveys which showed that people using the service, relatives and staff had a usually positive view of how the home was run. We were also shown a service development plan for the coming year which also indicated that the service was being thoroughly monitored and actions and developments were clearly identified. This showed that the provider responded to improvements identified and learnt from any events that occurred.