Jewish Care

The Princess Alexandra Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The Princess Alexandra Home is a care home that provides accommodation and personal care for up to 45 older people of the Jewish faith, some of whom have dementia. At the time of this inspection there were 45 people living in the home.

The home is currently going through a major redevelopment. The original building was divided into two units; Newland House and Edmond House. This is being re-developed to make way for a new home. The registered manager explained that the entire home will not be demolished until the new home is built. Currently a small section of the home has been demolished, including Newland House. People from Newland House have since been supported to move to Edmond house, which accommodates up to 45 people.

This inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a police investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risks related to that incident. This inspection examined those risks.

We saw that risks were appropriately managed. Risks to people's health and well-being had been identified. These were reviewed regularly to ensure appropriate action was taken to mitigate the risk.

Where accidents and incidents had occurred these had been appropriately documented and investigated. Relevant action plans had been met. This process ensured risks to people were reduced.

People were protected from the risk of abuse because staff had a clear understanding of the safeguarding process. Comprehensive vetting checks were carried out on new staff to make sure they were suitable to work with people who needed care and support.

People's medicines were handled safely. There were suitable arrangements for the recording, storage, administration and disposal of medicines in the home.

Staff supervisions, appraisals and staff meetings all happened regularly. Staff spoke highly of the management. They were confident they could raise any issues, knowing they would be listened to and acted upon.

People had access to health care professionals to make sure they received appropriate care and treatment. We saw that the home followed advice given by professionals to make sure people received the care they needed.

Staff treated people with dignity and respect. People were supported with care and compassion. Staff

understood the need to protect people's privacy and dignity. People told us staff knocked on their doors before they could enter their rooms.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. We found the home to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). 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.

People were supported to eat and drink sufficient amounts of fluids and encouraged to maintain a balanced diet. We saw that menus were very varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were well catered for.

People were supported to lead a full and active lifestyle. Activities were personalised. People were supported to develop their skills and pursue their hobbies and interests.

People received care that reflected their likes, dislikes and preferences. The care plans made reference to people's wishes and how they wanted their care needs to be met. This was supported by relevant documentation and tools.

Complaints were investigated and lessons learnt from them. These were assessed to see if any changes were needed to minimise the risk of similar concerns being raised and to improve the quality of the service.

The home had systems in place to continually monitor the quality of care and people were asked for their opinions and action plans were developed to address shortfalls. In addition, the home had a quality assurance system in place and gathered information about the quality of the service from a variety of sources including people who used the service and other agencies.

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 were kept safe because the provider had systems in place to recognise and respond to incidents. Following a recent incident, the service had responded to ensure people were safe from harm.

There were robust systems in place to ensure people's risks in relation to the environment were minimised.

People were protected from the risk of abuse because staff had a clear understanding of the safeguarding process.

There were appropriate recruitment and selection processes in place to make sure only suitable staff were employed to care for people.

Is the service effective?

Good

The service was effective.

Staff received induction, training and supervision to support them in their roles.

People had access to a range of healthcare services to make sure they received effective healthcare.

People's choices were respected and staff understood the requirements of the Mental Capacity Act.

People were supported to maintain balanced diets based on their preferences. They were provided with a suitable range of nutritious food and drink.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected by staff.

People and their relatives told us staff supported them with care

and compassion.

People receiving end of life care were treated with love and compassion, as were their relatives.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care and support. Their care plans recorded information about their individual care needs and preferences.

People were supported with their interests and activities.

There were systems and processes in place to receive and respond to complaints or concerns about the service.

Is the service well-led?

Good

The service was well-led.

People were included in decisions about the running of the service and were encouraged and supported to have their voice heard.

The home sought the views of people and their relatives through surveys.

This provided people with an opportunity to provide feedback about the service.

There were systems in place to assess and monitor the quality of the service. The quality assurance system helped to develop and drive improvement.

The Princess Alexandra Home

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 was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a police investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of people who preferred to eat meals in their rooms. This inspection examined those risks, including scalding from hot meals, choking, contact with hot surfaces and unsafe eating equipment.

This was an unannounced inspection by one inspector and it took place on 7 April 2017 and 7 June 2017. There was a gap between the visits because the on-going redevelopment work and other religious observances that fell in between meant we were not able to revisit immediately.

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 the service does well and improvements they plan to make.

We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

We looked around the home and observed how people interacted with staff. We looked at care records and associated risk assessments for eight people along with other relevant documentation. We looked at other

records including audits, maintenance records and policies related to the running of the home. These included staff recruitment, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures.

During the inspection we spoke with eight people who were using the service. They told us about the care they received. We spoke with six relatives. We also spoke with 14 members of staff which included the registered manager, care manager, service manager, assistant director, business manager for hotel services, and chef manager. During the inspection we spoke with a social care professional from a local authority for their feedback.

Good

Is the service safe?

Our findings

People receiving care told us they felt safe and secure living at the home. One person said, "Seriously speaking, I have no complaints." Feedback from relatives confirmed they were happy about the safety of their loved ones. One person's relative told us, "[My relative] is safe 100%." This was consistent with feedback from other relatives.

We looked at what arrangements were in place for managing risks appropriately. An incident at the home had highlighted potential concerns about the management of risk, particularly for people who preferred to have meals in their rooms. During this inspection we saw that risks to people's health and well-being had been identified. The risk assessments covered areas such as moving and handling, skin integrity, choking, scalding, nutrition, falls and infection control. Where risks were identified, say in such areas as choking or scalding, people's care plans described the actions staff should take to minimise the risks. These were reviewed regularly to ensure appropriate action was taken to mitigate the risk.

Where accidents and incidents had occurred these had been appropriately documented and investigated. For example, the home had reviewed the care plans and risk assessments of all people who preferred to have meals in their rooms. The home had implemented an action plan and during this inspection we saw that the actions were met. For instance, anti-slip mats were introduced for bedside tables and non-slip lap trays were put in place for those who did not want to use bedside tables. People were also monitored whilst they had meals. These measures ensured risks of burns and scalding from hot meals and drinks were reduced.

Possible risks to people's safety from the environment and equipment were well managed. Checks were carried out on all electrical equipment to ensure the equipment was safe to use. Other checks were carried out on gas safety, fire extinguisher equipment, fire alarm and emergency lighting. Health and safety checks were completed regularly. The home had a local arrangement for evacuating people in an emergency. However, this had not been verified as safe by the fire brigade. The home took immediate action to put in place personal evacuation plans (PEEPS) for people.

People were protected from the risk of abuse because staff had a clear understanding of the safeguarding process. Safeguarding and whistleblowing procedures were in place. All staff had received training on how to identify abuse and understood the procedures for safeguarding people. They were able to describe a variety of ways that people could experience abuse and the relevant reporting procedures, such as reporting to their line manager in the first instance, or where appropriate, the local authority or the Commission. Staff told us they were confident that any concerns reported to managers would be treated seriously and appropriately. We saw examples of where the registered manager had taken appropriate action in response to relevant information.

We checked to make sure people received their medicines as prescribed. There were suitable arrangements to ensure people were protected against the risks associated with the inappropriate management of medicines. The home had implemented an action plan following a local authority inspection that was

carried out in February 2017. For example, this had identified that medicines competency checks were inconsistent. We saw evidence that competency assessments were carried out with all staff who administered medicines.

We also checked medicines audits, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the home and were stored securely in locked medicines cupboards. This assured us that medicines were available at the point of need. People told us they received their medicines on time.

Current fridge temperatures were taken each day, including minimum and maximum temperatures. During the inspection (and observing past records), the fridge temperature was found to be in the appropriate range of 2-8°C. Past records also showed fridge temperature was kept within this range. We looked at 11 MAR charts and found no gaps in the recording of medicines administered, which provided a level of assurance that people were receiving their medicines safely, and as prescribed.

We looked at the recruitment process. There was evidence in staff files that new employees were checked before being allowed to commence work to ensure they did not pose a risk to people who used the service. Documents included proof of identity, job description and at least two references. Checks had also been undertaken to ensure that all the nurses who worked at the home had a current registration with the Nursing and Midwifery Council (NMC). The files showed checks had been carried out with the Disclosure and Barring Service (DBS).

People who attended the home were cared for in a clean and safe environment. Infection prevention control policies and procedures were in place. Staff demonstrated their awareness of the actions they would take to prevent the risk of cross infection.

Good

Is the service effective?

Our findings

People and their relatives were consistently complimentary about the competency of staff and the quality of care provided at the home. One person told us, "Staff are marvellous." Another person said, "It is a pleasure living here." A relative said, "In all [the years my relative] has been here, I have never heard staff being nasty to anyone." Another relative said, "They are absolutely brilliant here."

There was a training programme that was delivered to staff as part of the mandatory induction. Staff had attended essential training, such as Health and safety, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and infection prevention and control. Refresher sessions were also provided to keep their skills up-to-date. Staff also received training which was specific to people's individual needs, including pain management, wound care, peg feed, falls prevention and management and long term conditions such as diabetes, stroke and Parkinson's disease.

Revalidation training was provided to qualified nurses. In order to validate and continue practise, a nurse is required to undertake a minimum of 35 hours of continuous professional development (CPD) every three years. We saw that nurses were supported to participate in CPD in order to keep up to date with changes in clinical practice.

Staff had a four week induction training prior to commencing work. This was linked to the Care Certificate standards which is an identified set of standards of care which care staff need to meet before they can safely work unsupervised. This also included shadowing experienced staff to get a good overview of the service.

Staff had regular supervision and an annual appraisal system was in place. We looked at a sample of records of supervision sessions which showed staff were able to discuss key areas of their employment. Items discussed included recent issues involving people they supported, learning and development, work place matters and actions from previous meetings.

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires that as far as possible people make their own decision and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff understood the process to follow where it was thought people did not have the mental capacity required to make certain decisions. Records of best interests meetings were in place. For instance, one person had appropriate authorisation and input from professionals to enable them to continue receiving care from the home. All the required documentation was in place, including the best interests meeting

minutes, mental capacity assessment and a signed DoLS form. On the other hand, where people had capacity to make their own decisions, this was supported. For example, one person had requested to have bedrails up when in bed. Staff discussed the benefits and risks of bedrails and the person signed a consent form to confirm they were aware of the implications of their decision.

People were supported to eat and drink sufficient amounts of fluids and encouraged to maintain a balanced diet. We asked people if they enjoyed the food. One person told us, "I am a foodie. The food here is great." People could choose what they wanted to eat. Two choices of meals were provided and people could also order a different meal. Those with small appetites were encouraged to eat or offered an alternative meal. This ensured people's dietary intake was sufficient.

People's dietary preferences and choices were met because staff understood kosher dietary requirements. The provider employed chefs who are trained to prepare Kosher meals and culturally-specific meals including traditional foods for Jewish festivals and holidays.

People had access to a range of healthcare professionals. We saw that referrals had been made to relevant professionals including district nurses, occupational therapists, physiotherapists, speech and language therapists (SALT) and dietitians.

Good

Is the service caring?

Our findings

People told us that all the staff were kind and caring. One person told us, "I always get treated well." Another person said, "The care here is fantastic. You could not expect anything better." Relatives were also pleased with the care and support their family member received. One relative told us, "If you are to come to a Nursing Home, this is the place. The care here is second none." The home also received compliments about good care from relatives. For example, a comment from one relative read, 'we write to sing the praises of the staff in the home. They are an extraordinary and caring team. They have helped to make [my relative's] life as pleasant as possible."

People's privacy and dignity was promoted and respected. Staff spoke with people in a respectful way. They sat next to people when they were assisting them with meals or having a discussion. We observed that they knocked and waited to be asked in before they entered people's rooms. A staff member told us, "When we assist with personal care we make sure privacy is maintained; curtains drawn and doors closed." One person took time to explain how well they were treated by staff, and then concluded, "You couldn't ask for kinder treatment than that."

We observed positive interactions between people and staff throughout this inspection. Staff understood their role in providing people with caring and compassionate care. Staff spent a lot of time chatting with people and engaging people in meaningful activities. For example, we observed staff interacting well with people whilst engaging in activities. They always made sure people were comfortable and offered reassurances to people who may have had anxieties. For example, some people had anxieties about the duration of the redevelopment work that was taking place. We saw staff constantly reassuring people and explaining how the home would look after the work had been completed.

People were free to spend their time as they wished. We saw that where people chose to remain in their rooms this was supported by staff. We also observed some people in the communal areas going about their own business. People could also meet with their relatives in the private areas of the home.

The home ensured people received compassionate and supportive care when they were nearing the end of their lives. Their end of life care wishes were fully documented in their care plans and kept under regular review. We saw from these records that people and their relatives, where necessary were involved in decisions about end of life care. Where people chose to, we saw that the 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms had been completed. These had been constantly reviewed and updated. This ensured people's choices were met when they could no longer make the decision for themselves. We read some letters from relatives of people who had passed away, thanking the staff for the loving care and attention given during the person's last days. One relative commented, 'I am so glad [my relative] did not die alone in hospital. I am enormously grateful to all wonderful staff."

We observed that personal information was stored securely in locked cabinets. Relatives and people told us their permission was sought before their confidential information was shared with other healthcare professionals and we saw this documented in care files. This meant people could be assured their sensitive

information was treated confidentially, carefully and in line with the Data Protection Act.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their needs. One person told us, "You only need to raise a hand and somebody is there." Another person said, "[My relative] receives [specialist treatment] twice a week. She also has a 1:1 carer." A relative told us, "Staff always keep us informed. We are invited to meetings and reviews."

People received care that reflected their likes, dislikes and preferences. Assessments of needs were carried out before people moved into the home. As part of this process, people were encouraged to visit the home prior to moving in. If people expressed interest to move in, members of the management team visited the person to carry out an assessment to establish if the home could meet the person's needs. The assessments covered a range of needs including, personal care, medical care, food and drink, activities, and communication.

People's care plans were centred on their individual needs, preferences and goals. They covered a range of areas such as personal care, nutrition and hydration, mobility, personal histories, likes and dislikes and communication. The care plans made reference to people's wishes and how they wanted their care needs to be met. This was supported by relevant documentation and tools. For example, people at risk of falls had a falls prevention action plan in place; behavioural plans were in place for people who displayed behaviours that challenged the service; the home had created a system of communication that worked for people with communication difficulties, and body maps were in place for supporting people at risk of pressure sores. In all examples, we saw that people set their own goals and staff assisted them in achieving these goals.

Care plans were reviewed regularly and had been appropriately updated when there were changes. This ensured there was an up to date record for staff about how to meet people's individual needs. For example, one person had diabetes and their care had recently been reviewed by the nurse at the home. The review established their glucose levels within the blood were fluctuating outside normal ranges. Following this, a referral was made for a diabetic review with their GP. Other changes were introduced to the person's care, including quarterly podiatric review to prevent loss of feeling of feet, eye test every six months to prevent vision loss and diet management. The same process was followed for everyone to address their individual needs and to make sure their care was always up to date with their needs.

The home had been responsive to the needs of people and their relatives. For example, one person's condition had deteriorated such that their needs could no longer be met at the home. The person could no longer communicate verbally. The home in conjunction with the family organised for specialist care to be provided at the home. Visual aids and pictures were used to help with communication. For example, a magnetic board with different letters and numbers was used to meet their communication needs. The person was able to use the letter chart to spell out their message.

Relatives also told us the home had been responsive to people's needs, particularly, in light of the on-going redevelopment work on the site. One relative had complemented staff for being responsive to her mother's needs. The relative had written, "I just wanted to express my gratitude and admiration for all the staff. My mum was moving today from [one part of the building to another]. Everything that was asked of [the

registered manager] and her staff was listened to and dealt with."

The home worked with external agencies and partners to improve their responsiveness to the needs of people. The home worked with St. Luke's Hospice to improve how they responded and facilitated real choice over the place of care and death. The home also worked with its local partners including Harrow Falls Team to improve how it managed and responded to falls. As part of this, we saw that the home had consulted national guidance on falls, including the National Institute for Health and Clinical Excellence (NICE) guidance to develop the required tools. At this inspection, we saw new falls risk assessment tools and new prevention action plans had been implemented. He registered manager told us they had seen a reduction of falls since introducing the new approach.

Staff understood the cultural and religious needs of people. The home had its own kosher kitchens with trained chefs. We spoke with the chef of the home who understood the importance of providing traditional Jewish food. Shabbat and Jewish festivals were celebrated at the homes and we saw people participated in these.

The home had a varied programme of activities and entertainment for people. We spoke with the activities coordinator who took us through the programme. These included, board games, cards, puzzles, music, quiz, chair based netball, and pampering sessions. There were also visiting entertainers. Other projects included a wide variety of person-centred group and individual activities. These were organised in collaboration with Jewish Care's Creative Arts Team. The facilitators were qualified creative artists and therapists. Examples of these projects included, 'Age is not Beige' in which people were empowered to redesign one of the lounges in the home, 'The JOY' (Joining Older & Younger) Project – people visited a nursery near the home to interact with younger children in the community and 'It's a Good Life' - people were interviewed and filmed to create a documentary short film – the home launched a premier to which residents and families were invited. At this inspection, we saw this film was used with staff in person-centred care plan training.

The service had a complaints procedure in place which included timescales for responding to complaints. This was shared with people, their relatives and staff. One person told us, "I know where to go whenever I need to talk." Relatives felt the same and were confident complaints would be acted upon. One relative told us, "There have been some glitches but whatever it is it gets sorted."

Good

Is the service well-led?

Our findings

The registered manager was in place. She had worked at the service since 2010 and had significant relevant experience in health and social care. People and their relatives were happy about the quality of service. They described the leadership at the home in complimentary terms, including 'approachable', 'sincere', 'kind' and 'supportive'. Similar terms were used by staff. A staff member told us, "The managers are approachable. They are available whenever we want to speak to them."

There was a clear management structure in the home. Staff understood their lines of responsibility and accountability for decision making about the operation and direction of the service. The management team demonstrated a strong commitment to providing people with a safe, high quality and caring service and to continually improve. They shared with us how they were performing against their key performance indicators such as hospital admissions, falls per month, and unintended weight loss. This showed they had made improvements in these areas.

People knew who the registered manager was and found her to be helpful. The registered manager was well-informed about people's needs. She could tell us knowledgeably about the support each person was receiving. She was equally familiar with important operational aspects of the home, as did the clinical manager, service manager and assistant director of care services. We found them to be well-informed about their roles.

There was an open and inclusive approach to running the home. The home held regular meetings to enable people, their relatives and staff to share ideas and discuss any relevant issues. We saw minutes of the staff forum. Staff met quarterly with human resources representatives. A number of topics were discussed, including staff well-being, service development, concerns and issues. Relatives attended meetings with staff. We read minutes of the last meetings and saw that a number of topics were discussed, such as on-going redevelopment work at the home, people's activities, and housekeeping issues. We also read minutes of the 'service user advisory group'. This group was set up to encourage people's involvement in the on-going redevelopment of the home. Topics discussed included the interior designs, layout, furniture preference and choosing carpet and wall paint colours. People's suggestions were taken on board.

The home employed a range of ways to monitor the quality of the service in order to make improvements. Audits were regularly carried out on internal processes and procedures. There were regular surveys to give people, their relatives and staff an opportunity to add views on relevant topics. The local authority monitoring team also carried out periodic visits. Accidents and incidents were monitored for trends and learning points. We found improvements were always made where shortfalls were identified. For instance, a recent local authority visit had prompted an improvement plan, which the home implemented. Similarly, a recent significant incident had led to changes in how meals were served to people who preferred to have meals in their rooms.

The home worked in partnership with other organisations and the local health and social community to ensure they followed and shared best practice. The service had been involved in a range of projects. The

falls prevention programme involved the Harrow Falls Team and the home GP. The aim of the project was to reduce falls and improve quality of life in all Jewish Care homes.