Jewish Care

Selig Court

Inspection report

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Date of inspection visit:
31 January 2018

Date of publication:
06 April 2018

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 31 January 2018 and was unannounced.

This was the first inspection of this service since it registered with CQC in January 2017. Selig Court provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regular premises used for extra care housing; this inspection looked at people's personal care and support service.

Selig Court has 45 one and two bedroomed flats. It is run by Jewish Care. Priority is given to Jewish people who are Holocaust survivors or refugees from all parts of the world, aged over 60. On the day of the inspection there were 49 people living at the service, 21 of whom were receiving care and support from the service.

Selig Court is within a complex of other services run by the provider and people living there can access these facilities including restaurants and a day service. The service had a registered manager, which 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 told us they were happy living at the service, and the facilities were of a high quality and the standard of care provided was good. People told us staff were kind and caring.

Medicines were safely managed and the provider was in the process of updating the medicines policy to improve medicines management across the range of their services.

People's needs were identified and responded to well. Risk assessments were drawn up integrating people's views and care records were person centred. Care documentation had all been updated within the last 12 months or more recently if people's needs changed.

There was a wide range of activities for people to engage in which encouraged people to maintain varied and active lives and contributed to the service being personalised.

Staff told us they enjoyed working there and felt supported in their caring role. We saw they received regular supervision and training. Staff understood about safeguarding people from abuse and what to do if they had any concerns.

Staff recruitment was safe which meant staff were considered safe to work with vulnerable people. People told us there were enough staff to support people's needs, although some people told us they would prefer

the continuity provided by regular staff over agency staff.

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 at the service supported this practice.

People and staff spoke well of the organisation, the registered manager and the management team as they were responsive to people's needs and supported staff well.

The provider had a clear vision and credible strategy to deliver high-quality care and support. The strategy was well-embedded at this service. Systems at the service supported continuous learning and improvement. The registered manager and provider had a range of systems in place to check the quality of the service through quality audits. There were also systems to prompt management actions which meant care documentation was regularly updated. The service was in the process of reviewing care documentation to ensure there was no duplication of information which would further assist staff in their caring roles.

The service responded to people's concerns and complaints, and used this to improve the quality of care. The service learnt lessons and made improvements when things went wrong.

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. Risk assessments were in place and covered a wide range of needs identified.

Medicines were stored and administered safely.

There were enough staff to support people's needs and staff were safely recruited.

The provider ensured people were protected from the risk of infection.

Is the service effective?

Good

The service was effective. Staff were regularly supervised and received appropriate training in key areas to carry out their role.

People were at liberty to leave the premises as they wished and staff understood the need to obtain consent from people using the service.

There were kosher restaurants in the complex which people could either attend or have food brought to their flats. Some people managed their own food and meals but staff were available to provide support if necessary.

Is the service caring?

Good

The service was caring. People were treated with kindness and respect, and were given emotional support when needed.

People were asked for their views on how the service was run. The service supported people to maintain their cultural and religious requirements.

People's friends and relatives were welcomed to the service and the communal facilities were made available for individual as well as collective religious services.

The service promoted people's independence and ensured people's privacy and dignity was respected and promoted.

Is the service responsive?

Good

The service was responsive. People's changing needs were identified and responded to well.

People received personalised care that was responsive to their needs and the varied range of activities available to people living at the service further ensured care and support was personalised.

There was a complaints process in place and we found the provider followed their complaints policy effectively.

Is the service well-led?

Good

The service was well-led. The provider had a clear vision to support people. There were quality audits in place to monitor the quality of the care.

There were systems in place to prompt management action which meant care records were up to date and staff received supervision and were prompted to undergo training.

The registered manager and management team were well regarded by the people who lived there.

Selig Court

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 took place on 31 January 2018, and was undertaken by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their involvement was talking with people using the service to ask them their views of the service.

We gave the service 48 hours' notice of the inspection visit as we needed to be sure that the registered manager would be available for the inspection visit.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

The inspection site visit activity started and ended on 31 January 2018. It included a visit to the service to meet people living there, the staff working with them and to check records kept at the service. On the day of the inspection we visited one person's flat and viewed the care records in their home and we also met with a second person who was using the service. On 31 January 2018 we spoke with four care staff and the registered manager.

We reviewed the care records for four people living at the service to see if they were up-to-date and reflective of the care which people received. We also looked at personnel records for three 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, safeguarding issues, complaints and compliments. We also reviewed team and tenant meetings in the last 12 months and 28 accident or incident logs. We checked medicine administration records (MARs) for two people and reviewed historical records. We also checked how the registered manager ensured that essential services to the building had been maintained.

Subsequent to the inspection we checked quality assurance processes, and requested further specific information about the management of the service from the registered manager and activities co-ordinator.

The expert by experience spoke with six people so in total we obtained the views of eight people living at the service.

Good

Is the service safe?

Our findings

We asked people if they felt safe living at the service. They told us, "I feel very safe here and with the carers. They're always informing us how to stay safe." Another person said, "They always make me feel safe with them." One person was not so confident regarding agency staff as they told us they were less attuned to their needs. They told us "I don't always feel safe with the agency staff." We asked this person if they could give us more detail but they said they had no specific concerns. The registered manager told us they would review how to get regular feedback on people's experience of the care provided by agency staff.

There were systems, processes and practices in place to safeguard people from abuse. The registered manager had a log of all safeguarding events that had occurred, which set out the interim management plan to ensure people remained safe and the outcome of the investigation.

Staff were able to tell us about safeguarding and what they would do if they had any concerns regarding a person's safety. There was a safeguarding policy in place. One staff member told us, "Yes, I've read it and had training. I need to observe for any signs of abuse or neglect, might be bruises or marks, people might be acting differently, might seem more anxious. Need to record and report it immediately to a team leader or manager. I would always follow it up." Staff understood the importance of communicating to the registered manager and office staff any concerns and understood how to whistle-blow if concerns were not dealt with within the organisation.

Risk assessments were in place to support staff in their caring role. A generic risk assessment covered a wide range of issues including people's home environment, for example, the lighting, trip hazards or any infection control issues. Detailed risk management plans and risk assessments provided information for staff on issues such as people's mobility, medicines management and safety issues to both the person themselves and staff. Personal emergency evacuation plans (PEEPs) were in place to guide staff in how to support a person in the event of a fire. We noted one person who smoked in their flat did not have a risk assessment in place to provide guidance to staff in minimising the risk of a fire. By the time of writing this report the registered manager had developed this risk assessment.

The majority of people living at Selig Court managed their medicines on their own, or simply required support to take them whilst maintaining responsibility for them. Staff told us, "We remind and encourage but if they don't take it [medicines] we record it on the MAR and report it to a team leader or a manager." People told us, "They make sure I take my medication in a morning, but I do it myself twice a day as well." Another person told us "They make sure I always take my medication because it's for my nerves and I take it in a morning and in the evening, but I mustn't exceed the dose. There was a terrible mix-up with my medication a few months ago from the pharmacy but they rectified the problem for me."

For those where staff administered medicines, MAR sheets were in place. We could see from historical MAR records that staff completed these correctly and they were countersigned by a member of the management team as part of the quality audit. All MAR had an up to date log of medicines being administered even if they were in a blister pack. The registered manager told us that for the people they administered medicines for

they also managed the ordering of medicines so they were aware at all times of their medicine regime.

People's ability to take their medicine safely was risk assessed and where the service was required to administer medicines there was a detailed medicines risk assessment. For two people who had been risk assessed as not able to take their medicines, and there were also issues of capacity, a best interest meeting had been held and minutes recorded the decision to support this person by administering their medicines.

The registered manager told us that if additional boxed medicines are dispensed, for example, antibiotics, a member of the management team would complete a medicine risk assessment, then add the medicine to the medicine support plan and MAR with the information related to dosage and duration of course of the medicine.

The service was in the process of updating their medicines policy and competency assessments were being undertaken for staff in line with the new policy at the time of the inspection. Staff told us they received training in medicines administration annually and training records confirmed this.

Staff recruitment was safe. Records showed two appropriate references were obtained and Disclosure and Barring Service (DBS) checks took place before staff were considered safe to start working. However, the recruitment policy was out of date, referring to out of date police checks and did not stipulate the number of references required nor the need to account for gaps in employment. The registered manager told us the provider was aware the recruitment policy required updating. They sent us an updated policy by the time of writing this report. The provider was also introducing three yearly DBS checks for longstanding staff to ensure they remained safe to work with vulnerable adults.

There were enough staff to meet people's needs, as these were re-assessed regularly and this informed staff numbers. People told us they preferred being helped by permanent staff as opposed to agency staff. People told us, They haven't got enough permanent staff, so they use agency staff. The agency staff can be a bit willy-nilly, I've not been very happy with them." Another person said "It's a good service in the main but I tend to see different people. I only see one person on a regular basis and I would prefer a regular carer." Another person was critical of some of the agency staff. They told us "The permanent staff are very respectful, but the agency staff have no respect."

The registered manager told us they had mostly permanent staff but when they used agency staff they were from a pre-arranged list so the provider was confident staff were competent and trained in key areas. Staff were offered full time contracts to promote commitment to the organisation and continuity of care. However, where people had other private work the provider worked around these arrangements to retain good staff. When staff were going on leave, the service inducted an agency staff member to shadow the permanent staff for a week, so they got to know the people they would be supporting. Although this had a financial implication the registered manager felt this was a priority to meet people's needs safely and well. We discussed the comments from the people using the service regarding some agency staff and they undertook to obtain further feedback from individuals using the service as well as pressing ahead with recruitment for more permanent staff.

People told us, "The carers are always on time and they log in in my care book." Another person said, "Sometimes they are late." The provider was introducing a new electronic care system which would both devise rotas and check on time carers arrived at the service. This was being piloted at the time of the inspection.

We could see the registered manager had a system to oversee accident and incident logs and appropriate

action was taken. There were also significant event forms completed if they related to people using the service which were then stored on care records. The registered manager could show us they learnt from issues that arose. For example, a recent safeguarding concern had highlighted security issues to the building. The registered manager had taken remedial action by immediately reminding people not to let people into the building and options for security were discussed at the next tenants' meeting. The registered manager was aware there was no oversight of the trends of accidents or incidents which they knew could be useful so planned to develop a system for this.

People were protected by measures in place to prevent and control infection. Communal areas were clean and there were hand sanitisers in hallways. People told us care staff used gloves and aprons and staff told us these were freely available as were bottles of hand sanitiser for staff. One staff member told us the service provided her with special gloves due to her allergy which she very much appreciated. Another said, "We get provided with gloves, aprons, shoe guards, face masks and hand gel, there's never a problem with supplies." We were shown a small supply they carried around with them all the time.

Good

Is the service effective?

Our findings

We found people's needs and choices were assessed, and care treatment and support were delivered in line with best practice. People's needs were assessed prior to care being provided and their needs were set out through a range of care documents. Staff were aware of people's needs and could tell us how they met their needs.

We asked people if they thought staff were competent in their caring role. One person told us, "They are all very good, they've been here a long time and are some of their best carers. They come every morning to shower me and help me get dressed." Another person told us, "I've no problems at all with the service or the care that I receive." A third person told us, "The carers change quite a bit, and seeing different faces makes me anxious. Overall though the quality of care is very good."

Induction of staff consisted of three days training and shadowing experienced staff at the service. Staff told us they read the key policies at induction, but as it was too much to absorb in one go, team leaders also discussed these with them. Agency staff were booked to work for a week and they also undertook a similar induction which included shadowing of the people they were due to support.

There was a training matrix in place that showed that staff took courses in key areas to enable them to carry out their role. These included moving and handling, medicines administration and competency, fire safety, safeguarding adults and infection control and prevention. Staff also undertook additional courses in end of life care, dementia, Mental Capacity Act (2005), food handling and Jewish way of life.

Prior to January 2018 there were named first aiders at the service, other staff were expected to call on these staff or call the ambulance service or Hatzola, the Jewish ambulance service. As of this year there was a programme of first aid training which the provider told us will be completed by the end of March 2018 for all staff. Health and safety issues were covered at induction and refresher courses were required every three years. The next course was planned for April 2018.

We saw that regular supervision took place with staff. Staff told us, "Supervision is with a team leader and is every two months, more often if needed, you just have to ask. Supervisions are useful and team leaders and the manager are all very approachable and helpful, the manager is excellent, he really listens." Another staff member told us, "Supervision is about me, which is really nice."

Records showed that staff had an appraisal each year to review their learning needs. The provider encouraged and supported staff to undertake nationally recognised courses and a dinner event was held annually in celebration of staff achievement and long service for the provider. In 2017 five staff from the service were celebrated for their achievements in gaining external qualifications. One staff member told us they were currently enrolled in an external course, paid for and supported by the provider. They told us, "I am doing it through them, therefore I am very pleased to do it. We care about people and they care about us."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS), and in the community these are applied for by recourse to the Court of Protection. There was nobody subject to DoLS at this service.

We found 'Consent to Care and Treatment' forms were on all care records and were signed. They covered a wide range of issues such as providing first aid, contact with G.P, ambulance or paramedic if required. They also referred to consent to enter the property and carry out care duties as well as use of the key safe.

At this service people's mental capacity was assessed in relation to specific issues. The majority of people had full capacity to make decisions. A staff member told us the, "Mental Capacity Act is about letting people make their own decisions, even if they are only small ones." Staff told us, "No-one is forcing them to have care."

On two occasions people were not considered to have full capacity to administer medicines themselves we could see that best interest meetings were held and documented to evidence appropriate processes had been taken to support the person.

The majority of people were able to arrange and attend health care appointments by themselves. Some people needed practical help, such as calling the GP on their behalf due to hearing issues, or arranging for a taxi to be called. A small amount of people needed support to actually attend appointments if family or friends were not able to do this, and care staff accompanied people. However, care staff were not usually present at the appointment. The registered manager explained that if a person was coming out of hospital or people wanted their involvement they offered this support, but most people were able to manage their health themselves or had the support of family and friends to do it.

A staff member told us,"If I found someone in need of medical attention I would call the Jewish paramedics who will advise if the person needs to go to hospital or not. If we are not sure about a client we can ask the assistant manager she is very quick to respond to health care concerns." Another said. "Not many doctors come here; there is a surgery very close. We escort people to health appointments, people use community services. We use a taxi or people go in a wheelchair."

There were various options for people with regard to eating. Some people prepared their own food in the flats, or were supported to heat up meals by care staff. People who may be at risk of poor nutrition had a nutritional assessment carried out annually or more regularly if required, which indicated if they needed further support in this area. There were also two restaurants on site which a number of people used regularly and routinely.

People told us, "I mostly eat in the dining room and the food is always very good." Another person said, "They're always very good meals; I've just had a very nice lunch. I tend to have them delivered to my flat." A third person said, "I occasionally go downstairs for meals. It's kosher food in the dining room and I'm a practising Jew so all the food I have upstairs is also kosher."

One person was less enthusiastic about the food and said, "I don't really feel that the food is always up to standard, but all the food is Jewish." People had the opportunity to contribute their views on the menu and

the quality of the food served at the restaurants. There were seven meetings a year for people to contribute their views as to the menu and their dining experience. We saw minutes of the meetings which were well attended.

The environment was well maintained and facilities at the service were of a high standard. A second person likened the service to a luxury hotel. They said, "If this building was in central London it would be compared to the [name of luxurious hotel]!" People's flats were spacious, with a kitchen area set aside in the living room, with cupboard space and built in cooker facilities.

Communal areas were well decorated, and there were facilities for use for all the people living there. These included a piano for use, and a large screen TV to enable cinema nights to be offered with tenants choosing the film. There was wifi available in the communal areas whereas people were responsible for wifi in their own apartments.

The building is fully wheelchair accessible as it has been built for the purpose of providing accommodation and care for older people. There are two communal living rooms at the service which enable people to mix socially and which are available for religious events.

Although each tenant had their own wet room shower facilities, there were two assisted bathrooms for shared use should people's needs deteriorate. One bathroom had a shower chair that lowered into the bath. The hallways were wide and this enabled people to store their walking aids and equipment outside of their flat. There was also a room on the ground floor to store spare wheelchairs, or people's mobility aids and scooters for use outside. There were rails around the communal hall areas and space for people to have wheelchair/tripod outside of their flat.

Selig Court opened onto a courtyard garden which was well kept and which provided a range of seating options. One person told us "There's a nice garden here though and other places to go and sit with other people."

Good

Is the service caring?

Our findings

We could see that the service focused on providing a service of a good standard and this was reflected in the kindness, respect and compassion that were shown to people, and also reflected in the services and activities made available to people.

We could see the service supported people to express their views and be actively involved in decisions regarding their care in a number of ways. All care records were signed by the person receiving care. People spoke very highly of the care staff. They told us, "They're always very polite, kind and gentle." Another person told us, "The carers are all very friendly, very polite and helpful." A third person said, "The carers are very polite and friendly. I couldn't be in better hands". A fourth person said, "They're all very good to me." Only one person highlighted a difference between permanent and agency care staff stating they felt there was a difference in attitude from agency staff.

The service offered dignity and respect to people in a number of ways. Staff said, "I show respect by saying please and thank you, knocking on the door, asking and not telling, encouraging and promoting independence. You have to give people time to do things for themselves." Another staff member told us, "Yes, I think there is enough time to let people do things themselves and it's not always quicker to do it yourself. If I am giving personal care I will cover the part of the body not being washed with a towel or blanket and ask people if they want to do it themselves."

Staff told us how they ensured people were shown privacy, for example by closing curtains and doors when providing personal care; by knocking before entering the flat even if they were using the key from the 'keysafe' outside and always waiting for a response before entering a bedroom or bathroom. Staff told us how important it was to relate to people as individuals, by reading their care record and talking with people staff understood people's preferences and wishes. Staff told us, "The care plan gives us background and we talk and people tell you the story of their life" and "I show respect by saying please and thank you, knocking on the door, asking and not telling, encouraging and promoting independence, you have to give people time to do things for themselves."

People were encouraged to be as independent as possible. One staff member told us, "We promote independence by asking what people want so they are the ones making the choice, we encourage clients to do things for themselves. During personal care, washing and dressing, most people can do something for themselves even if it's only a little thing. I would not see someone struggle but I do let people try to do as much as they can for themselves." Another staff member told us, "Just because someone is old doesn't mean they are not able anymore, they might not be able to do everything the way they used to but everyone can do something." One person told us, "It's independent living here, however more and more have to have care so not really independent anymore. It's a lovely place and beautifully clean. I've been here for seven years, it's an upmarket place just like a hotel."

We were also told clients had an emergency button on an armband, which was connected to a mobile phone which staff carried about. Staff said "All client calls come through and we respond to anyone who

calls/sets the alarm off. This enables people to have greater independence as they know if they fall they will get help quickly".

Tenants meetings were held approximately every two months. We could see from records that people discussed issues that were important to them such as catering, security and issues with maintenance. The registered manager also used the opportunity to convey information to people using the service and obtain their views. People also gave their comments at the catering forum held on seven occasions throughout the year.

People's religious and cultural needs were met in a number of ways at Selig Court. Care records noted people's religious and spiritual beliefs; staff all received training in understanding the Jewish way of living including dietary laws and the building had been purpose built to accommodate requirements not to break the Sabbath by using electrical equipment on that day. For example, doors were able to be opened by either electronic or manual means. The communal lounge was available to people to use for Shiva, a period of mourning following a person's death. In this way the service accommodated the religious and cultural needs of both the people living at the service and their friends and family. One person told us, "I'm a non-practising Jew but they do recognise and celebrate all the Jewish festivals here." Another person told us that the majority of the carers were not Jewish but "they're trained to understand Jewish practices". A third person told us, "They do keep to the faith here and keep all the Jewish festivals. They certainly keep the values here."

The provider was aware that some family members lived far away so they made available an en-suite for relatives to rent at a subsidised rate. These considerations supported family involvement with people living at the service.

Good

Is the service responsive?

Our findings

Care records were detailed, comprehensive and personalised with background information. They contained a photo of the person with key information and key contacts. They covered a wide range of areas including people's physical and daily living needs, their mental health and issues of well-being. Three out of the four records reviewed on this inspection gave staff detailed advice on how to provide care to people, the fourth provided detail on needs but gave less information on how the person wanted their care to be provided. The majority of people were able to articulate their needs so this did not impact on people's care. One staff member told us, "The care plans detail what a client likes and needs. I always listen to what the person wants."

All records had been updated in the last 12 months and many more than once. The registered manager had a system to prompt management actions including updating of support plans and reviewing documents. The registered manager was in the process of reviewing and altering the paperwork across the service and there were some documents in place that duplicated information about people's needs. We found two occasions in which there was contradictory information for staff, although staff we spoke with were clear about people's needs so it did not impact on their care. For example, one person required specific support with continence issues in the morning and evening but their needs in the day differed, however, this was not clear in the documentation. The registered manager told us that as part of streamlining the documents they would reduce the number of care documents and ensure there was continuity of needs across all documents.

People's care needs were reviewed at least yearly or more often if their needs changed, and spot checks of people's care were logged on care records. In this way the service ensured people's care was responsive to their needs. One staff member told us, "Even through someone's care plan says they like to have breakfast at a certain time doesn't mean that's what happens. You ask every time and if they are not ready go away and come back later. Care is very flexible, we don't just assume, we ask."

The registered manager was in the process of setting up the key worker system so care staff would have a greater understanding of people's needs. The registered manager told us care staff were sometimes asked by people with disabilities to read or write emails or letters for them.

Although there was no requirement to provide activities for people to participate in, the service ran such a wide range of activities for people to participate in that this contributed to the personalised nature of the service. The service ran an extensive range of workshops, crafts, outings and events for people to attend if they chose to. These included exercise classes, flower arranging, dancing, book groups and a film club. Volunteers provided massage therapy for free. People told us, "They have a coffee morning to introduce new people and their backgrounds, so you can really get to know people very quickly." Another person said, "It's feels like a family here, far better than the last place."

In the week following the inspection there was a musical event with two opera singers and a buffet. For some events people had to financially contribute, but the provider had made funds available so all paying

events were heavily subsidised. One person told us, "There's plenty of entertainment; last night, two opera singers came and there was a buffet and wine. We had to pay £10 but that's not bad at all. We go on outings to the cinema and theatre, but we can manage those outings without the carers."

Many activities took place on site, but the service also facilitated people to remain active in their life outside of the service and to maintain relationships and activities they had always enjoyed. People told us, "I'm not very mobile so don't go out often. You have to book a carer to go out." Another told us "I also go out to my club to play bridge three or four times a week. It helps to keep me alert. I go in a mini-cab, but I don't need my carer for that because I'm meeting a friend there." On the day of the inspection we saw people arriving and leaving for activities in taxi's either travelling alone or with carers or volunteers. These arrangements helped people to receive a personalised service.

There was a complaints process in place which distinguished between informal and formal complaints. Formal complaints were logged when a person put in writing their complaint and were then responded to by letter. Informal, that is verbal complaints were logged and dealt with, but people were made aware of the outcome through verbal feedback, no letter, and this was recorded by the registered manager so they could monitor themes, and ensure issues were resolved. All types of complaint were dealt with promptly and records showed the outcome of complaints. People told us, "I've no concerns at all except, as I've said, I would prefer regular carers." Another person said, "Can't fault the service at all but if I did have any concerns I would report them straight to [registered manager's name]."

One person told us they were awaiting resolution of an issue related to the building, which was dealt with by a separate part of the organisation. People did not always identify they had been asked for feedback on the service despite having a review of their care or attending meetings for tenants. We drew this to the attention of the registered manager who said they would make this clearer to people when obtaining their views.

The service has a written 'End of life' policy that aimed to ensure that people were confident that their preferences and priorities were acknowledged and that all staff were clear on their responsibilities. The Service supported people at the end of their life to die in the manner that they would like which included dying at home or in a setting of their choosing depending upon their given circumstances. The service worked closely both with people and with family carers to ensure that the best interests, preferences and choices of the person were understood in advance. The service discussed advanced directives with people and families and ensured that the person's wishes were documented and discussed with relevant individuals. An advanced directive is a living will which gives power of attorney to another person in the event that the she or he is unable to make decisions in the future.

People were supported to remain at the service until their end of life with support from additional health professionals. One staff member told us, "I recently had end of life training which was really useful. He covered how to talk about death, especially how some things can be offensive to some people, how to work with someone who is dying and people's different cultural beliefs." Another staff member said, "We are part of their life and we are there at the end of their life."

Good

Is the service well-led?

Our findings

The service was well led in a number of ways. The provider had a clear vision and credible strategy to deliver high quality care and support to people using the service. The criteria for admission to this service was transparent which helped the registered manager and the management team focus their work to provider a personalised and high quality service to meet the needs of the older people living there.

The registered manager had effective systems in place to monitor quality of care delivered. For example, they had a system that prompted when care plans, risk assessments and reviews were due and this meant care documentation was up to date. Similar systems were in place for spot checks, supervision and training. There were health and safety quality checks by a senior manager on a regular basis that covered environmental issues as well as training, supervision, medicines audits and risk management. The registered manager had a log of all people living at the service which collated information from the PEEP's and which could be used by the fire service in the event of a fire.

People who used the service, staff and other stakeholders were engaged in a number of ways. Staff received regular supervision and told us they valued it. Team meetings were held regularly, there were five in 2017 which provided an opportunity for staff and the management team to discuss people's needs and best practice. Staff told us, "Yes, managers are approachable and easy to talk to. Everyone shares ideas, [registered manager] always makes sure everyone is listened to in team meetings, he's very supportive." Another staff member said, "Supervisions are useful and team leaders and the manager are all very approachable and helpful, the manager is excellent, [registered manager] really listens." Staff told us management support was always available.

We found the registered manager open and transparent and we could see from records and management actions they were keen to learn and improve and innovate to sustain the service. One staff member told us, "Jewish care is a good organisation to work for, yes they listen to us and ask our opinions." We found staff to be motivated and proud of the service.

There were regular tenants meetings at the service and the catering forums provided an opportunity for people to give their views. People told us, "I think the service is brilliant and [registered manager's name] is very good. We're enjoying it here, it's purpose built and very well-run." Another person told us, "[Registered manager's name] is a very busy man but he's always very polite and helpful. If I was in need, he would be there for me." A third person told us, "[Registered manager's name] is a very pleasant man and I do see him occasionally."

Family members were invited to a forum yearly and we could see from review documents that where appropriate they were involved in people's care reviews. The registered manager was mindful of the importance of family involvement for people living at the service and understood that whilst some people living at the service were not religiously observant sometimes their children or other family members were. Staff ensured they were aware of this and acted in ways to support this, for example, not contacting family members on the Sabbath or ensuring family members could visit the building without using electronic doors

(on the Sabbath). We asked one staff member how they knew if the service was good. They said, "People tell me they are happy and say thank you very much, and I can feel they are."

The provider encouraged charitable giving to the organisation which meant there was funding for social activities. This, combined with the use of volunteers meant there were enhanced activities available at the service, many of them free, for example, massage therapy. Others were subsidised so people's contribution was kept to a minimum. This meant people were encouraged to lead varied and active lives.

We saw the implementation schedule for an electronic care records system which indicated it was going to be introduced between December 2017 and March 2018 across the provider's services. At the time of this inspection the service was piloting the service and running a dual paper based and electronic system. The provider told us the new system would provide electronic tracking of care staff which would automatically monitor the start and end of visits to service users or any missed calls. The service manager also told us the system would enable regular auditing of information and enable the service to reduce the number of late or missed calls. The provider had highlighted additional benefits of the new system which they hope would improve quality, these included aligning appropriately trained care staff to work with service users as staff training records would be input to the system, and quality reports for the provider and other stakeholders.

Another innovation the provider was introducing at the time of the inspection was an electronic learning system to supplement formal training courses, accessed via a mobile phone application. These short sessions on specific subjects were to remind or provide guidance to staff. We saw evidence of this style of learning in relation to pushing wheelchairs, food hygiene and dietary laws. The provider intended to roll this out fully across the organisation in 2018. One staff member we spoke with had used this new facility the others were either due to have further training before they could use it or their phone needed altering to enable them to use it. The provider had a plan to upgrade phones where required.