Leo Baeck Housing Association Limited

Clara Nehab House

Inspection report

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London
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

We inspected this service on 6 June and 4 July 2017. The inspection was unannounced. Clara Nehab House is a care home registered for a maximum of 25 people of the Jewish faith.

At the time of our inspection there were 22 people living at the service. The service was located in two adjoining houses on a residential street with access to a back garden. There was a lift to access upstairs and there were accessible bathing facilities for people with mobility problems.

We previously inspected the service on 13 January 2017 when we found repeat breaches of the regulations in relation to the safe management of medicines and the recruitment of staff. Following the inspection in January we served the provider with two Warning Notices in relation to the repeat breaches. This inspection was carried out to review actions taken in relation to the Warning Notices and to also undertake a full comprehensive inspection of the service.

At the time of the inspection, there was a registered manager in place at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were happy living at the service and we saw kind and caring interactions between staff and people living at the service on the day of the inspection.

We found recruitment processes had improved and appropriate references and checks were now in place prior to staff starting work at the service.

Medicines were now safely managed at the service.

Staff understood people's needs and preferences and told us they were supported in their role. Supervision had been taking place more regularly since January 2017 and we could see that refresher training was planned for staff. Although staff understood about safeguarding and consent their understanding was not always appropriate to their role within the service.

Care records were up to date and staff had appropriate information to support people living at the service.

There was a range of activities at the service and people enjoyed participating in both collective and individualised activities and trips out.

People were supported to maintain good health through regular access to healthcare professionals such as GPs and the local general hospital.

People were happy with the range of food available. People's cultural and religious needs were facilitated by staff.

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. We found the service to be compliant with the legislation.

Quality assurance audits were now taking place in a number of key areas and we could see that the registered manager had made improvements to the service following the warning notices issues earlier in the year. The service was no longer in breach of the regulations relating to the safe management of medicines or the recruitment of staff.

There was a record of essential services such as gas and electricity being checked, and equipment was safely maintained. There was clear documentation relating to complaints and accidents and incidents.

We saw fire drills were now taking place regularly and staff had received training in fire safety. Since January 2017 the provider had commissioned a fire safety consultant to work with the service.
We have made recommendations in relation to safeguarding and following best practice in relation to head injuries.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Staff understood about safeguarding people from abuse, but not all staff had an understanding appropriate to their role.

Medical advice had not been sought for people experiencing a head injury from a fall.

The staff recruitment had improved and we could now see appropriate checks were now in place prior to a staff member starting work.

Medicines were safely managed.

Essential services were maintained so the premises were safe.

Is the service effective?

Good

The service was effective. Staff received training in key areas to enable them to carry out their role effectively. Supervision had been taking place with more regularity since January 2017.

People had access to good health care.

People told us they enjoyed the food and were given a choice of menu.

Is the service caring?

Good

The service was caring. We saw staff were kind and caring towards people living at the service.

People's cultural and religious needs were met by the service.

The garden was well cared for and enjoyed by people living at the service.

Is the service responsive?

Good

The service was responsive. Care plans were detailed, personalised and up to date.

There were a wide range of activities for people to be involved in at the service.

Complaints were dealt with promptly and appropriately.

Is the service well-led?

Good

The service was well led. There was a culture of openness at the service. .

Staff meetings took place at the service as did meetings for residents.

The registered manager had employed additional management support to assist in establishing quality management systems and we could see that these were being embedded at the service.

Clara Nehab 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.

The inspection took place on 6 June and 4 July 2017, and was unannounced. It was undertaken by one inspector for social care, a pharmacist inspector 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.

Before the inspection we reviewed information we held about the service. This included information from previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we met and spoke with nine people living at the service and seven relatives who were visiting on the day of the inspection. We also spoke with the registered manager, two deputy managers, a member of the care staff, the finance manager and a member of the kitchen staff.

Following the inspection we communicated with the provider's chief executive and obtained feedback from three health and social care professionals.

As part of the inspection we observed the interactions between people and staff and discussed people's care needs with staff. We also looked around the premises including the garden and two bedrooms.

We looked at four records related to people's individual care needs, and three staff recruitment files. We checked supervision records for four members of staff and the supervision chart for the team for 2017. We also checked all staff training records..

We looked at the records associated with the management of medicines, including eleven medicine administration charts, and checked medicine stocks against records for eight people.

We also checked management of people's money, complaints, accidents and incidents and safeguarding. We also reviewed documentation related to essential services such as gas, electricity and the maintenance of equipment.

Requires Improvement

Is the service safe?

Our findings

One person told us, "It feels safe here because they care for you. Comforting to have them shower you. There is a call button." Another said, "Yes. It feels safe here." A relative told us, "I feel mum is safe here. There is a mat and if she treads on it, it sets off alarm and somebody checks she is ok. Always someone keeping an eye out." Another family member told us, "Mum feels safe here. She has got to know the people." We were also told by a family member they thought "they were reasonably safe. They are going to improve the fire escape situation."

At the last inspection in January 2017 we found staff had Disclosure and Barring Service (DBS), criminal checks, in place at the start of working for the service. However, of the four staff files we looked at two staff did not have written references in place at the time of starting work. We also found no recorded evidence to risk assess a reference or any evidence of a discussion with a previous employer when a reference was received that was not entirely positive about a newly employed member of staff.

At this inspection we found the service was no longer in breach of the regulations in relation to recruitment. References and Disclosure and Barring Service (DBS) criminal checks were in place prior to staff starting work at the service. We found one reference without a company stamp or signature so there was no evidence it was from the referee, but this was a third reference for a person and they already had two suitably verified references. We noted there were a variety of application forms and referee forms in place and not all asked for a list of previous employment, or the capacity in which references were being given. Following the inspection the registered manager updated the forms to ask for this information. This would enable them to be confident they received references from the most recent employers where staff previously worked in a social care setting, and referees were provided by appropriate personnel.

Volunteers working at the service had DBS checks in place so were considered safe to work with vulnerable adults.

At the last inspection in January 2017 we found a number of issues with medicines management. These included errors in stocks against records and recording. The service was managing medicines in a central place but there was a plan to move people's individual medicines to their own room.

At this inspection we checked medicines storage, medicines administration record charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in locked medicines cupboards within each resident's rooms. Items requiring refrigeration and controlled drugs were stored securely elsewhere.

Current fridge temperatures were taken each day. We checked the log and found the fridge temperature to be in the appropriate range of 2-8°C. Room temperatures for medicines cupboards in each resident's room were observed each day and monitored for deviations above 25°C. On the day of inspection we found two cupboards which were too warm. We brought this to the attention of the manager who informed us they were in the process of rectifying this. By the second day of the inspection one cupboard has been moved

and fridge packs were being used if the temperature went above the safe limit.

People received their medicines as prescribed, including controlled drugs. MAR charts showed no gaps in the recording of medicines administered, which provided a level of assurance that people were receiving their medicines safely, consistently and as prescribed. This included short term medicines such as antibiotics. However, we found that although the provider was recording the administration of topical creams, they did not record the site of application by way of a body map, for instance. This meant we could not be sure where medicated creams were applied. We brought this to the attention of the manager. By the second day of the inspection they informed us body maps were being used.

We spoke with two people who reported that they took and received their medicines in a timely and correct manner. Running balances were kept for medicines that were not dispensed in the monitored dosage system and we cross checked eight people's medicines with their MAR charts and found that there were no discrepancies. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed, for example, one or two paracetamol tablets, we saw a record of the actual number of tablets administered to the person. For entries that were handwritten on the MAR chart, we did not see evidence of two signatures to authorise this, in line with national guidance. By the second day of the inspection we were told this was now implemented.

Medicines to be disposed of were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. These were monitored by the provider in their monthly cycle ordering process, which tracked the amount of medicines returned. Controlled drugs were appropriately stored in accordance with legal requirements, with weekly audits of quantities done by senior staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour were not controlled by excessive or inappropriate use of medicines. We saw nine PRN forms for pain-relief/laxative medicines. There were appropriate protocols in place which covered the reasons for giving the medicine, what to expect, time intervals between doses and the maximum daily dose allowed.

Medicines were administered by senior staff or care co-ordinators that had been trained in medicines administration. We observed a member of staff giving medicines to a resident and found that staff had a caring attitude towards the administration of medicines for people. For one person who self-administered their own medicines, we found that this was currently being done safely and there was a risk assessment in place for this, along with monitoring of the resident to ensure they continued to obtain their medicines safely.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider including safe storage of medicines, fridge temperatures and stock quantities on a daily basis. A recent improvement made by the provider included ensuring that the record form for recording medicines related errors was updated to include more comprehensive information should there be a referral for safeguarding. This had been highlighted from a previous medicines error and showed the provider had learned from medicines related incidents to improve practice. The service was no longer in breach of the regulations in relation to the safe management of medicines.

Although staff were able to identify safeguarding issues, not all were confident discussing how to respond to the concern appropriate to their position within the organisation. Not all staff understood about

whistleblowing and how to progress concerns outside of the organisation if necessary. We were also aware due to a notification that staff had not raised concerns about poor practice in relation to another member of staff at the time of the event. We discussed these issues with the registered manager who told us there was a safeguarding course in place in the coming two months. They also said they would discuss these issues with the wider staff team to ensure staff understood their responsibilities in this area.

We recommend the provider ensures the staff are fully aware of best practice in relation to safeguarding adults.

People's risks were documented within the care plan as the new format covered what the need was for the person, how it affected the person and what the service could do to help. Risks identified included and addressed falls, behaviours, skin integrity, communication and eating and drinking. For example, one person's risk assessment noted a person became frustrated at their poor mobility and as a result may shout out and provided staff with advice on how to support them with this. Separate risk assessments were also in place for management purposes. The format was one of scoring to determine dependency levels in a number of areas including falls, neurological condition and skin care.

Staffing levels had been increased between the inspection in June 2016 to January 2017 at night with an additional member of staff on duty. We could see the registered manager calculated dependency levels on a regular basis to assist with determining staffing levels. However, two people who lived at the service and one visitor told us "They are short of staff. They take a long time to get upstairs." "Not always enough staff but I ring the bell frequently at night and they come quickly. Think they should have more people to go shopping with you". Conversely another family member told us said "Sufficient staff around. " We discussed this with the registered manager who undertook to discuss this with people and their families and get more formal feedback on the subject.

We checked accident forms completed in 2017, the majority of which were overseen by a member of the management team and the registered manager reported on them monthly to the provider. However, we noted that out of 36 accidents or falls, eight people had experienced an injury to their head, but no medical advice had been sought at the time of the injury although staff action noted monitoring the person's condition. We discussed this with the registered manager who undertook to ask staff to seek medical advice at the time of the injury as the service does not employ trained medical staff. Since the inspection the policy has been updated to include action to take in the event of a head injury.

We recommend the provider ensures staff follow best practice guidance in the event of people experiencing a head injury.

We checked the records for the management of people's money and could see that they were reconciled on a regular basis, usually monthly.

The service was clean throughout. A food hygiene inspection was undertaken in January 2017 and a rating of five stars, the highest, was given to the service. Actions had been recommended, for example, a screen to be placed at the window to stop insects entering when the window was opened, and we could see these had been implemented. On the day of the inspection food was sealed but not labelled. We discussed this with the registered manager who could evidence they had liaised with the contractor to carry out more spot checks to check labelling.

Servicing of key areas including gas, electricity, hoists, call bell system and the lift had been undertaken in the last 12 months.

We noted in the last two inspection reports, in June 2016 and January 2017, the lack of fire drills at the service. The service had sought advice from a fire safety specialist since the inspection in January 2017.In addition, the fire authority had reviewed the service in September 2016 in relation to fire safety and found arrangements were suitable. Fire safety training had taken place for all staff members in September 2016 and April 2017.

The service had undertaken a fire risk assessment in March 2017. Two fire drills had taken place in May 2017. Staff had been noted to lack confidence during the first drill and it was recommended a further inspection took place to also clarify how many staff were required for evacuation. At the second fire drill, records evidenced difficulties using the equipment for moving people from second to ground floor. As a result a decision had been made to evacuate people to four safe rooms on the first and ground floors, if people could not easily mobilise outside of the building to await the fire brigade.

We could see from records the registered manager had been exploring other options for equipment to move people but had not been successful in finding a solution at the time of the inspection. We could see following the inspection the registered manager had made contact again with the fire equipment company to obtain advice on appropriate equipment.

The service was considering whether an external fire escape route was feasible at the service, but this was a longer term option. People on the upper floor were able with assistance to walk down stairs to the first floor. A third fire drill was planned as a follow up to the most recent one this summer.

Good

Is the service effective?

Our findings

One person told us "Staff [are] very good. They deserve a medal." People were happy with the care provided by the service.

We could see from records that an induction took place but records were not always completed accurately or signed off by the manager. Staff confirmed they received an induction which consisted of shadowing experienced staff, reading policies and being given information about the service including health and safety information.

On the day of the inspection we could see training information was held in a number of places which made it difficult to see what staff had undertaken which training and what was outstanding. Following the inspection the provider sent us two training matrices for 2016 and 2017 and this showed some staff had undertaken refresher training and others were due to undertake it. Dates were booked for training courses and included key areas such as moving and handling, medicines administration, safeguarding, first aid and fire safety.

The registered manager showed us the service plan to implement the Care Certificate for all staff starting in August 2017 with planned end dates.

Since the last comprehensive inspection in June 2016 there were long periods when staff had not been supervised or there were no records to evidence this had taken place. We could see that supervision was taking place on a more regular basis since January 2017. Checking supervision records we saw that one staff member had received four supervisions in the last 12 months. However, another member of staff with minimal previous experience in the caring field had worked for six months at the service without formal supervision, although they had received supervision twice since February 2017. Another staff member had started in March 2017 but had not received supervision at the time of the inspection.

We discussed this with the registered manager who told us they were now carrying out more regular supervision themselves, and were auditing supervision was taking place. We saw from January 2017 a chart had been drawn up by the registered manager and we saw evidence of them chasing supervisors to check supervisions were being carried out.

People were happy with the food. We were told "the food is reasonably good. Plenty of food." and, "Excellent. More choice than you get at home." We saw fruit being served mid-morning which looked like a mixture of fresh and tinned fruit. We also observed that at lunch people were supported to eat where necessary and the environment was quiet and calm. People's cultural and religious needs were met by a kosher menu.

People had access to medical services as required . A family member told us, "they are very helpful about taking [relative] to the dentist or hospital appointment." One person told us they would like more independence when walking and another family member told us "I think they should pay more attention to

exercise. [Family member] needs more exercise. They could walk more than she does."
Another person told us, "They make me use a walking frame although I don't need it." Asked if she had a fall she said "No, they think I might. I would like to be allowed to do things. I said I don't fall and would choose not to use it (walking frame) if not made to do it. They think I need it." We could see from care records that one person had improved their mobility since moving to the service and no longer used their wheelchair. We discussed independent mobilising with the registered manager and they explained people had accessed physiotherapists and occupational therapists for advice and guidance regarding exercises and the staff supported people with these. Some of these visits were privately paid for and the outcome was not always written in care records although the registered manager believed they followed advice of the health professionals. The registered manager undertook to record the outcome of these visits more accurately on care records, and continually review if people were able to obtain greater independence.

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 in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had fulfilled their responsibilities but were waiting for the outcome of DoLS assessments for people at the service.

Care staff understood the need for consent when offering care to people, and one person told us "They always ask before they do anything". Not all staff understood the broader implications of the MCA and DoLS and this was important for day to day care giving. The registered manager undertook to ensure training was embedded following a course and would consider how best to do this.

The building provided access for people using wheelchairs due to a lift and accessible bathrooms and the garden had a ramp fitted to enable people using wheelchairs to access it.

Good

Is the service caring?

Our findings

We saw kind and caring interactions between staff and people using the service. One person told us "I love being here. I used to come for respite. I know I have people to fall back on, people to help me if I need it". Another said, "They [the staff] are doing wonderful work. Caring is excellent. I am finding it difficult as lost my independence. [I] have visitors and they are made welcome. I read the paper and I go out, for example, to the cinema. Get a taxi there and back." A family member told us, "They are always doing something for her. She is calm and confident. Friends visit. She was isolated in her flat. She gets involved. It's given her a new lease of life." Another family member told us, "They react to people. If they see people have a need they respond to it. They show loving care and tenderness. If someone needs feeding they are patient." The views of people and their carers were summed up by one visitor, "It's not an institution it's a home, it's a good location and people pop in."

The new care plan format did not have a place for people using the service or their families to sign that they agreed to the plan. A family member told us they did "discuss the care plan with me. They respect it when I said I did not want her to go to hospital." We discussed this with the registered manager who told us the service was still working out how to involve people in this new care planning process. Their involvement was required when people moved into the service as they or their families had provided information to draw up the care plans in the first place. The registered manager understood it was important to involve people and their families in the reviews of their care on an ongoing basis and was exploring how best to do this. They were aware that different solutions were required to cater for people's mental capacity and understanding.

Staff understood people's preferences and were able to tell us about people's histories which was positive, particularly for people with memory problems.

Care plans identified what people could do and staff could tell us how they encouraged people to be independent. One person told us, "You go to bed any time you want to. I like to get up early. You can choose when you want to. I have made friends here."

People's cultural and religious needs were met by the service. Food was kosher, and religious services from a local synagogue were screened to the home to enable people to participate in and keep with religious observance. The service also supported people to celebrate Jewish festivals.

The service had some volunteers working at the service. One was supporting people to use the computers . We were told the computers had been adapted to make them easier to use.

People's rooms were personalised and they had recently been refurbished with a wet room. The garden was spacious and well kept. The lounge looked out onto the garden so people could easily be taken in their wheelchairs or walk outside to get fresh air.

Good

Is the service responsive?

Our findings

At the last inspection the registered manager told us they were updating their care plan documentation. The service had sought support from a specialist experienced in working with people with dementia to help do this. The new process involved the dementia specialist working with the care staff to gain their views of people's needs and how best to support them and then this forming the basis of the new care plan. We could see a number of these had been updated with a plan to complete the remainder in the coming months.

The new format covered a wide range of areas including health and well-being, personal care and skin care, communication, mobilising and sleep and night care. These were person centred and contained useful information on people's preferences and routines. Care plans also provided detailed information regarding people's histories so staff understood who was important to a person and could ask people about their lives in a meaningful way.

A wide range of activities took place at the service. These included a yoga and meditation group; exercise classes; flower arranging; gardening, cooking and arts as well as activities arranged by a local synagogue. One person told us "I come down all day, with people all day. I have made friends here. I like the activities and table games like scrabble."

We saw on the notice board in the hall that two outings to the theatre had been planned. We were told "There are activities like fitness and I have a private physiotherapist. School children come in regularly to see us and ask questions." Another person told us, "I like the exercise." Another person told us "I have a little bed to grow strawberries and tomatoes. I had to insist I could get into the garden on my own."

Family members also spoke well of the activities. "She is treated well, care is more personalised. They are proactive and call when she is running out of things and ask me to bring more. Activities are engaging".

In the garden there are two bungalows in the garden, one is used for independent living. The other was sometimes used for activities in the summer. We saw in this bungalow a very large and varied display of art produced by the people living at the service. People also used the space to cook food in, or bake.

There had been one complaint in the last 12 months at the service and we could see this had been dealt with appropriately and in a timely way. People and their relatives told us they knew how to make a complaint and found the registered manager responsive if there were any issues raised. One relative told us, "They take notice when you raise something" and gave an example of questioning medicine prescribed which they felt needed reviewing. This had been followed up appropriately resulting in a change of prescription.

Good

Is the service well-led?

Our findings

Over the last 12 months the service had brought in additional management support in the form of a dementia specialist, a medicines specialist and a fire safety consultant to improve the systems required for running the service safely and in a personalised way. In addition, an additional deputy manager had been employed at the service on a permanent basis.

We could see that since the inspection in January 2017 more effective systems had been set up by the registered manager with the support of their deputy managers. For example, auditing of medicines was taking place on a monthly basis, and reviewed medicines for all the people living at the service.

The registered manager could evidence a supervision spread-sheet had started from January 2017, and the registered manager was now checking staff were receiving supervision on a regular basis. We saw mails from the registered manager to staff reminding them of their supervisory responsibilities. The registered manager had themselves been supervising staff more regularly from January 2017 which was important to ensure new staff in particular had the necessary support and guidance.

The new care plan format had been introduced which encouraged a more personalised approach. There was a plan in progress to update the remaining care records in the coming months. Since January 2017 a new recruitment process and pack to support staff had been developed.

Staff told us they felt supported and team meetings took place on a regular basis. Training was taking place, but the registered manager acknowledged they had to ensure the understanding was embedded as this was not evidenced in relation to the range of understanding of safeguarding issues and the MCA.

We saw there was a spread-sheet identifying when staff visas ran out and when longstanding staff required a new DBS as the service was committed to renewing them every five years. Other quality audits covered environmental issues.

People and their relatives spoke well of the management team. One person told us, "I don't know her name but she is around and friendly, walks over and talks to you. I was recommended to come here and would recommend it to others".

A family member said, "Staff wonderful. Attitude has to come from the top. [Registered manager name] is more administrative. [Deputy manager name] communicates well. She has a wonderful way with the residents. I felt a warmth as I walked in through the door. Can come in any time. Nothing to hide."

One person living at the service said, "They have residents meeting, I make suggestions and they listen". A family member told us, "I am happy with way it's run. If had a substantial issue I would go to manager; small issue I would take to carer." Another family member told us, "Staff are wonderful and management know everything".

The registered manager was aware new systems had to be embedded at the service, and told us that she was working with the local authority quality team to implement further improvements.

To keep up to date with best practice, the registered manager told us they attended the workshops and meetings run by the National Association of Jewish Care Homes and Barnet Quality Forums.