Service To The Aged

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 25 April 2017 and was unannounced. The service was last inspected on 10 November 2015 and was rated as Requires Improvement.

Service to the Aged is a nursing home for up to 60 older people, it provides nursing care to people of the Jewish faith so they can continue to practise their faith and be a part of their local community. Some of the people living in the home have dementia; the home has a dedicated Alzheimer's unit. At the time of the inspection 56 people were living in the home.

We completed a comprehensive inspection on 16, 18 and 19 February 2015 where we found breaches of regulations relating to staffing, staff training, and consent. We carried out a further inspection on 10 November 2015 and found that improvements had been made to address these breaches of regulations.

There was a registered manager in post. 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.

Medicines were managed safely by staff trained to administer them and safeguarding procedures and records were robust.

Risk assessments were reviewed and incidents were analysed to see how they could be learned from to reduce the risk of them happening again.

The home was free from odour and clean and staff were using infection control equipment appropriately.

The home had in house physiotherapists to help people mobilise and exercise. Referrals were made in a timely way for health needs and nurses were knowledgeable and confident.

Staff fed back the training could be more classroom based. We saw evidence that staff were supported through supervisions, appraisal and regular staff meetings at all levels.

The principles of the MCA were being followed but some staff lacked knowledge in this area which identified a training need.

People said the food could improve. The registered manager had listened to this and people were going to meet with the caterers to make suggestions.

People said they were happy in the home and staff were kind and caring and respected their dignity and privacy. Relatives told us they thought the care was consistently good.

Activities were regular and well attended and provided a range of mental and physical stimulation.

Care files were person centred and captured needs well. People and relatives said they knew how to complain and complaints were recorded and responded to in line with the provider's policy.

Robust audit systems were in place and the management team were passionate about improving care standards. Relatives and people fed back to us that they had seen an improvement in the home over time.

We made a recommendation that the home provide additional training to staff in the area of consent and MCA.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People told us they felt safe and safeguarding issues were reported and recorded.

Risks were clearly assessed with actions on how to reduce them. There were enough staff to meet the needs of people.

Infection control practises were followed and the home was clean.

Is the service effective?

Requires Improvement

The service was not always effective. There were gaps in consent documents and some staff lacked knowledge when asked about the MCA.

People received timely support with their health needs.

People fed back the food could improve, the registered manager had arranged for people and relatives to meet with the caterer to feed back.

Staff felt supported by supervision. Staff said the induction was comprehensive but we found induction records were not signed by staff.

Is the service caring?

Good

The service was caring. People told us staff were kind and caring.

We saw respectful friendly interactions throughout the day between staff and people.

People were supported to practise their faith in the way they wished to.

Families were involved in care planning and relatives and other visitors said they felt welcomed into the home.

Is the service responsive?

Good

The service was responsive. People's needs were responded to promptly on the day of the inspection.

People and relatives said they knew who to complain to. Complaints were recorded and the complaints policy followed.

Activities were well attended and people said they enjoyed them.

Care files were person centred and focussed on the individual.

Is the service well-led?

Good

The service was well led. Changes had been introduced to improve the communication in the home.

Audit systems were robust and information on incidents was gathered and learned from.

People knew who the management team were and had confidence in their ability to run the home.

Most staff said they felt supported by the registered manager.

Service to the Aged

Detailed findings

Background to this inspection

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

This inspection took place on 25 April 2017 and was unannounced.

The inspection team consisted of three inspectors, one nurse and two experts 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.

We looked at notifications sent in by the service, where we are sent information on important events such as an injury. We talked with 16 people living in the home and ten relatives. We met 14 staff and talked with four nurses, six care staff, the registered manager, and deputy manager. We looked at a range of care documents including care files in detail for ten people and seven staff files. We also looked at the rota, records of incidents, complaints and management audits to check the quality of the service.

We observed interactions between care staff and people during the day, activities, and a meal time. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with health and social care professionals and the local authority to gather feedback on their interactions with the service.

Good

Is the service safe?

Our findings

People said "I do feel safe", "Oh yes they are very strong about safety" and "Yes I do, very safe." Relatives we spoke with also felt people were safe. One relative said "Oh indeed. The safest he has been since he has been ill. On A to Z scale I would rate it has A+."

People were protected from harm through safeguarding processes and systems of reporting issues when they arose. Staff spoke confidently of what they would do if they suspected abuse taking place towards a person they were caring for and were able to describe what this might look like in the setting of the service. Staff also knew about whistleblowing if they had a concern they felt was not being heard, they knew where to go and who to report it to. We looked at safeguarding records and saw where a concern was reported it was passed on to the local authority safeguarding team and recorded to say what stage of investigation it was at and the outcome. Most staff had been on safeguarding training. However we saw that five staff had not done any training in safeguarding, two of whom had worked at the home for several years. We asked the registered manager about this and they sent us information to show the staff had been booked on safeguarding training within the next two weeks.

Risk assessments were in place for people covering risks that were individual to them such as weight loss, falls and behaviour that was challenging to staff. We also saw behaviour plans where appropriate so staff could support people and understand how their dementia manifested itself in their behaviour.

We looked at whether there were enough staff to meet the needs of people. We saw that staff on the day matched the rota and there were two nurses on each floor, with five care staff supporting up to twenty one people. At night there were two nurses to cover the whole home and six health care assistants. We saw that some people had one to one care or companionship from carers not employed by the home and these were in place. We asked the registered manager how the interactions and information between private carers and those employed by the home were managed. The registered manager told us that private carers and those employed by the service filled out a handover sheet with information of how the person was doing and what care had taken place that was signed by both carers before the next carer starting working with a person. We requested a copy of this handover sheet and were provided with one.

We found on the day of inspection there were enough staff to meet people's needs. The home was supported by family members and members of the community at certain points of the day. For example, we saw at lunch that large numbers of relatives came to eat with their family members and supported them and kept them company during the mealtime whilst care staff were supporting other people to eat. People said "I think they have enough staff. Never noticed a problem" and "I think there is enough staff." Relatives fed back to us there could have been more staff at night and that sometimes there was a wait for call bells to be answered. On the day of inspection call bells were answered promptly, and people told us sometimes they had to wait when it was busy in the morning.

People told us they didn't feel there were any restrictions on their freedom or rights. They said "I can do whatever I like there is no problem", "I can say whatever I like" and "I have no issues. They respect

everything I tell them."

We looked at how medicines were stored, ordered and administered and found they were managed safely. We observed medicines being administered and saw nurses were checking people had taken their medicines before recording they had taken them. Medicines were locked away safely and administered by staff that had completed training in administering medicines and had their competency checked. We did not see any gaps in medicines administration records. People told us they were happy with how their medicines were administered. It was clear which medicines people needed to take in what dose and for what reason in care files.

Staff wore gloves and aprons appropriately throughout the day to ensure infection control practises were being followed. The home appeared odour free and clean and there was a dedicated housekeeping service to ensure a high standard of cleanliness was kept to.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We saw that DoLS applications were being made when required but there were some gaps in forms. For example on one application the section for the reason the application was being made was not filled out fully. For another person there was a gap where their DoLS authorisation ran out in November 2016 and a new application was not made until December 2016. Staff understanding of the MCA was lacking in some areas and care staff were not confident talking about how they can support people who might not have capacity to make decisions about their care despite having attended training.
We recommend that staff are provided with further training on consent and the MCA to deepen their understanding.

Feedback on food was mixed, with many people saying there was not enough choice. People said "It leaves something to be desired. There isn't much choice"; "The food is nice. I get plenty, really spoilt" and "There always seems to just be chicken." On the day of inspection we saw that people were not offered a choice of meals for lunch but were offered which cut of chicken they preferred. For people who needed food that was pureed it was in separate groups on the plate rather than together so it appeared more appetising. We asked the registered manager if they thought people were happy with the food. They told us there was a meeting later that week with caterers and people living in the home because people had been expressing dissatisfaction at the food generally and specifically at food that was supplied for a recent religious festival.

Some people needed support to eat through a percutaneous gastronomy (PEG) tube. A PEG is where a small tube is passed through the stomach wall so that people who might be at risk of choking or struggle to swallow can be fed medicine or food through the tube. Records around PEG feeding and for those who were at risk of malnutrition or needed encouraging to drink were robust. One relative said "My [relative] is PEG fed and this works very well, with no infections whatsoever."

Staff said they had a good induction, we were provided with the induction handbook that new staff used when they started working in the service. We asked for individual records of induction to show that each new staff member had confirmed they had covered specific areas of induction such as safeguarding and fire safety. The deputy manager told us the home did not have individual records of induction for new staff. We looked at training records and saw staff had completed basic training to meet the needs of people. Staff fed

back to us they would prefer classroom based learning rather than online courses as they learned more. The registered manager told us they provide some classroom based training for courses such as moving and handling but most of it was done online. Staff said they had regular supervision which they found helpful and we saw records that supported this.

Relatives we spoke with said they felt confident in the knowledge and competency of the staff. They said "they know what they are supposed to do for him"; "I think they are all good at their jobs. I have no complaints", and "I do feel confident in them. I trust them to know what they are doing". We saw the home had recently been supported by the local authority as part of a project to improve care and reduce hospital admissions. This was evident in peoples care files and advertised throughout the home that they were using this method of caring and monitoring people to provide effective care. Elimination charts and health recording was consistent in care files and timely referrals were made to health services when required.

The home had a visiting GP once a week and also could visit when required. One person said of health related visits arranged by the home "You have to make an appointment, very good actually." The registered manager told us they made use of other health based teams to reduce crisis admissions to hospital and seek advice when people became unwell and needed further medical intervention than the nurses could provide. The home employed three physiotherapists whose role was to continually assess people and provide support with mobilising and promoting independence and comfort.

Good

Is the service caring?

Our findings

People told us staff were caring. One person said "I think they are always kind" and another said "The staff here are always looking out for your best interest." Relatives also said they felt the same way and that "Yes. They are all so nice without exception" and "they are always pretty caring to my [family member]. They are always checking in on her and making sure she is alright. I can't fault them" and "I think they look after her better than I do."

Throughout the day we saw that interactions between care staff and people were consistently kind and gentle. Staff spoke to people as individuals, using the name they had recorded as preferring and referring to individual interests and preferences. Every person we spoke with said they felt looked after and supported and were happy with the care in the home.

We observed lunchtime in both the large communal dining area on the ground floor and on the other floors with smaller dining rooms. People were not rushed when they needed assistance to eat, one person who arrived late to lunch was encouraged to take their time and enjoy a cup of tea afterwards. Care staff sat next to people they were supporting to eat and waited for them to finish before offering them more, talking and encouraging throughout the meal and making eye contact. The atmosphere in the home was calm, people were chatting throughout the day and we heard and saw laughter throughout the home, in people's rooms and in communal areas. We saw that staff were pleased to see people and greeted them warmly with smiles.

We saw that the home was dedicated to meeting the cultural and religious needs of people. There was a library with prayer books and space for a rabbi to visit and lead prayer. There was also a leading female member of the local community who came in to meet with women in the home to discuss prayer. All food in the home was kosher as per the Jewish faith. The home observed festivals and religious observances throughout the year and had instructions around the home for non-Jewish people to ensure they were respectful of people's needs. For example, light switches had signs on for visitors to not switch them off on Shabbat. New staff who were not Jewish had as part of their induction some time spent with a Jewish staff member so they could explain to them how to respect the people living in the home and their faith.

People told us that staff respected their wishes and how they wanted their care to be provided. We asked people if they felt their privacy and dignity were considered by care staff, they said ""Yes they always knock and use my first name" and a relative said "Yes the few things I have noticed like knocking on the door before coming in or asking me to leave when they will change her. Things like that." People told us they felt informed about what was going to happen, one person said "They always tell me what they are doing, like we are going for a shower and they will ask me if that is ok."

There was a sense of community in the service, the registered manager said "SAGE itself is a community where relatives and friends can gather and support their family and practise their faith". The registered manager told us of links with local community centres and synagogues and how involved relatives were in people's care. We saw a continuous stream of visitors throughout the day who were welcomed by staff and who sat and ate with their relatives and knew the staff. We saw some evidence of families being involved in

peoples care planning and discussions recorded where families had fed back or made a suggestion about how the care might be different. One relative said "I get a phone call telling me what is happening. They will also tell me when I visit."

Good

Is the service responsive?

Our findings

The service responded to the needs of people promptly throughout the day of the inspection. Call bells were answered and when anybody asked for anything they received it promptly. Staff were good at predicting people's needs because they knew what they liked and disliked. One person asked at lunchtime to have fish and the nurse they spoke to requested it from the kitchen straight away. People were checked on regularly and staff engaged with them often to see if they were having their needs met. We did not hear any person call out in distress or requesting anything that was not provided.

Care files were personalised and person centred. They contained information about people's preferences and how they wanted to be cared for. Needs were described and tasks detailed so that it was clear for care staff what needed to be done and how the person liked it to be done.

One person fed back to us that they felt their needs and comments were not being responded to. They told us staff encouraged them to use a continence pad rather than the commode and the person wanted to use the commode for greater independence. We discussed this with the registered manager and they agreed they would meet with the family and the person to discuss what the person wanted to happen.

Activities were well attended. There was an exercise session in the morning, over 20 people attended; the area where the activity took place was screened off so that people felt they were having their privacy respected whilst taking part in the activity. People told us they enjoyed the exercise and found it invigorating. We also saw one of the activities co-ordinators with a group of 10 people reading some articles and generating debate and discussion. We asked people what they thought of activities put on by the home, one person said "I get involved in some of them, exercises and films. I am always asked to participate."

Throughout the day people were supported to go and sit in the garden in the sunshine and get some fresh air with care staff and relatives. We saw that people were encouraged to get out of bed, in the morning most people had breakfast in their rooms. At lunchtime we saw most people were downstairs or had taken part in some activity. The registered manager said they wanted people to get out of bed and socialise and encouraged staff to spend time with people, they said "any member of staff in a resident's room can have a meaningful moment." We asked the registered manager about people who stayed in their beds through choice, they told us that the activities team make time twice a week to go into people's rooms and have a conversation or reminisce with them.

People said they would speak to the nurse or the manager with any complaints and felt comfortable doing so. Relatives said "No complaints but we do pose questions to them or make observations and they respond appropriately and as we would wish as a family" and "I can't think of anything to complain about. But I would speak with the Floor Manager if I need to." Complaints were recorded in a log with actions taken and how the complainant was responded to and when an outcome had been reached. Replies to complaints were within the timeframe in the provider's complaints policy.

We saw meetings for people and relatives advertised for each floor throughout the home. One relative told

us "We have meetings all the time and if I am not happy about something then I can talk to them about it." We asked the manager about feedback from people about the home, they told us there was a yearly feedback questionnaire for people to fill out and "the feedback is every day ongoing." We saw a compliments folder with lots of emails and cards from people saying thank you to the home for taking care of their loved one.

Good

Is the service well-led?

Our findings

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. There was a registered manager in place and a support structure for running the service day to day and ensuring care was of a high standard.

There were robust audits and governance systems in place to monitor and improve the quality of the care provided. We saw evidence of audits taking place for care plans monthly and saw an increase in the number that met the quality standards each month to show that care plans were improving over time. The registered manager said that one of the changes they had introduced was new care plans to better capture needs. We saw analysis of numbers of people who were admitted to hospital and a breakdown of incidents and accidents. The home kept details of where infections had been recorded so they could try and prevent them from happening again. We saw monthly nutrition reviews and health and safety assessments of the home.

The registered manager told us "my first loyalty is always to the residents", they said they had felt communication had needed improving when they came into post and had introduced new ways of sharing information so staff and relatives were better informed. We saw there were scheduled meetings for senior carers to share best practise, meetings for floor managers, and a health and safety meeting was scheduled for the day of the inspection. The registered manager was a nurse and had clinical oversight of the home. There were clinical meetings that we saw minutes for that discussed weight, DoLS, safeguarding, pressure sores and all new admissions. We also saw a memo sent out to staff every month to keep them informed of any training or updates to the home.

Some staff fed back to us they did not like the way changes had been introduced but most staff said they felt well supported and happy in their roles. Supervision and appraisals were taking place. One staff member said the registered manager was "a very good home manager, very accommodating and hard working." We asked the registered manager if they were supported, they told us they felt supported and had supervision that was helpful from the provider, and the trustees were knowledgeable and experienced in healthcare.

The management team were visible and known by people and staff. People told us they recognised the registered manager. They said "She is fine, a very good communicator", "By face I know who she is. It is a good care home and it has improved over the years." And "Yes she does [spend time with people] most meal times."

The home had been working in partnership with the local authority quality team and had changed how they recorded key information about people so they could better meet their needs. Staff had attended training and shared what they had learned with other staff so the whole team could benefit from partnership working.