Sydmar Lodge Ltd

Sydmar Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This was an unannounced inspection that took place on 21 and 28 February 2017. At the last inspection in May 2016, we checked on the provider's progress with ensuring safe medicines management and found that this was sufficient.

Sydmar Lodge is registered to provide accommodation and personal care for up to 57 people, although the registered manager told us the maximum practical occupancy was 48. There were 48 people using the service at the time of this inspection. The service specialises in dementia care and is operated by a national care company.

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 and their relatives generally reported overall satisfaction with the service. For some, improvements could be made but it was still "eight out of ten." Others were very satisfied and full of praise.

There was good feedback about improved management of the service under the new registered manager. However, we found some concerns around how the service ensured that people received high quality care. There were some weaknesses in terms of service-wide communication in support of the effective care of people and with ensuring accurate care records.

We also found that professional safety advice was not always adhered to. Risks associated with the prevention of Legionella were identified in July 2016 but had not been addressed at the time of this inspection. Proper maintenance of one passenger lift was only being completed at the time of the inspection.

Whilst people felt safe in the service, some did not think there were enough staff. We saw an occasion where one person had to wait a while for their request to be addressed. The registered manager told us she was introducing a documented system of checking response times to call-bells as a result of this inspection, and we have recommended that people's feedback in relation to staffing availability be considered.

Despite these concerns, there was much good practice taking place at the service. People at the service had a strong collective voice that helped influence how the service was run. This included through regular house meetings, and being asked to contribute towards staff recruitment and development decisions. Due to ongoing feedback about the quality of meals provided by the in-house catering service, the service arranged for a number of people to meet with members of the catering service's senior management team. This had helped to make improvements to people's experience of meals.

The service provided an extensive range of activities and entertainers that many people enjoyed. People were enabled to maintain and develop connections with the local community, visitors were made very welcome, and there were weekly trips out using the service's minibus. The service even had its own choir.

The service promoted a Jewish ethos but welcomed people of all faiths. A number of Jewish customs and celebrations were therefore practiced at the service. There was ongoing training of staff on these matters by a Jewish staff member.

Community healthcare professionals provided strong praise of the service and staff capability. People received good support with healthcare and nutrition, and their medicines were safely managed.

There were established systems of assessing risks to individuals and taking action to prevent harm. People's care plans had been recently improved on and so better reflected their individual needs and preferences and the care that they received. This was a significant achievement for the service.

There was much praise of how committed and kind staff were. The service had many staff who had worked there for a long time, and was not using agency staff. There was good training and support of staff. The service demonstrated strong commitment to checking and supporting staff to have caring approaches to people. It was evident that many staff and managers had developed great fondness for people using the service.

There was clear evidence of service-wide improvement being facilitated through the new registered manager's approach. In particular, the culture at the service was more open, inclusive and empowering, to both people using the service and the staff supporting them. The service was aiming at high quality care and was increasingly providing it.

There were overall two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe. Risks associated with the prevention of Legionella were identified in July 2016 but had not been addressed at the time of the inspection. Proper maintenance of one passenger lift was only being completed at the time of the inspection.

Whilst people felt safe in the service, some did not think there were enough staff. A documented system of checking response times to call-bells was introduced as a result of this inspection, and we have recommended that people's feedback in relation to staffing availability be considered.

People's medicines were safely managed, and people were protected from abuse. There were established systems of assessing risks to individuals and taking action to prevent harm.

Is the service effective?

Good

The service was effective. There was strong praise of the service's and staff capability including from community healthcare professionals. There was good training and support of staff.

People received good support with healthcare and nutrition. Whilst people using the service expressed varied views on food quality, the service had made great efforts to improve their experience.

The service was embedding the principles of the Mental Capacity Act 2005 into its practice, and so respecting people's right to consent to care.

Is the service caring?

Good

The service was caring. There was praise of how committed and kind staff were. The service demonstrated strong commitment to checking that staff had the right attitudes during recruitment, and that once working at the service, their ability to interact well with people was checked on and developed. The views of people using the service were integral to this.

The service had many staff who had worked there for a long time,

and was not using agency staff. This consistency of staff helped positive and caring relationships to develop.

Is the service responsive?

Good

The service was responsive. A range of activities and entertainers were provided at the service that many people enjoyed. The service enabled people to maintain and develop connections with the local community, and there were weekly trips out using the service's minibus.

People's care plans had been recently improved on and so better reflected their individual needs and preferences and the care that they received.

People at the service had a strong collective voice that helped influence how the service was run, particularly through regular meetings. Concerns and complaints were listened to and addressed where possible.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Whilst the provider had a number of systems for governance of the service, these were not always effective at ensuring appropriate improvements were made. There were some weaknesses in terms of service-wide communication and ensuring consistently accurate care records.

However, there was clear evidence of service-wide improvement being facilitated through the new registered manager's approach. In particular, the culture at the service was more open, inclusive and empowering, to both people using the service and the staff supporting them. The service was aiming at high quality care and was increasingly providing it.

Sydmar Lodge

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 21 and 28 February 2017 and was unannounced.

Before the inspection, the registered manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked for any notifications made to us by the provider, any safeguarding alerts raised about people using the service, and the information we held on our database about the service and provider.

The inspection was carried out by one inspector, a pharmacist specialist, and two Experts by Experience, who are people with personal experience of using or caring for someone who uses this type of care service.

There were 48 people using the service at the time of our first visit. During the inspection process, we spoke with 26 people using the service, 14 people's relatives, five care staff, four other staff, the deputy manager, the registered manager and the regional director. We also gained the views of nine community healthcare professionals about the service.

During our visit we looked at six people's care plans and care records, and 15 people's medicine administration records. We checked the personnel files of three staff members and records about the management of the service such as about accidents, incidents, complaints, governance, and safety. We then requested further specific information from the registered manager about the management of the service following our visits.

Requires Improvement

Is the service safe?

Our findings

Most people told us the service was safe. One person said, "Yes, it's quite safe here, they do their best." Other comments included, "There's no problems getting around", "I feel safe in their hands" and "I feel very safe, even at night." Most relatives commented similarly, for example, "She is protected and looked after here" and "I feel my mum is very safe. They never let her do anything on her own and they never leave her in her room on her own for too long."

The service had a designated maintenance person working full time. They showed us records of what they checked on a regular basis. This included that the staff call-alarms in people's rooms were working correctly, that window-restrictors in people's rooms were secure, that wheelchairs and bed-rails were safe, and that fire equipment was working fine. Their role included some repair work, and to help ensure external contractors visited when needed.

When we checked the temperature of a few hot water taps in people's rooms during our first visit, one was too hot to hold a hand in. At our second visit, the weekly check records had identified a few cases like this and others where the water was not hot enough. After our visits, we were sent a plumber's report of how these concerns had been addressed.

We noted that the monthly records of boiler flow and return water temperatures were only at the required temperatures on one occasion across the previous nine months for one boiler, and on three occasions for the other. On six of the nine occasions, the flow temperature records for one boiler were over 10 degrees lower than required. However, the records did not usually identify that any action was needed. The July 2016 professional Legionella report identified this matter for urgent action, but records could not show that the matter had been addressed. That report identified a number of other action points, some of which were described as 'urgent.' We brought this to the registered manager's attention.

Subsequent to our visits, we were sent an updated action plan dated 3 March 2017. It showed that many matters had now been checked as addressed, but that some needed further work, with quotes due back for this by the end of the month. The plan included that further checks of the boiler water flow temperatures had taken place and were now at the correct temperatures, and so no further work was needed. However, accompanying records for one of the two boilers on 3 March 2017 did not back this up, as the flow temperature was still below the safe temperature of 60 degrees Celsius for the third consecutive time in 2017. We discussed this further with the provider, but at the time of drafting this report, the provider had not supplied evidence to demonstrate that in respect of the control of Legionella risk, hot water systems in the premises was safe to use.

The above evidence demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that regular professional checks took place of much of the service's equipment and environment. This included for hoists and slings, portable electrical appliances, and gas safety systems. The

local fire authority recently informed us of satisfactory standards at the service.

Records showed that since October 2016, both passenger lifts in the service had needed professional input due to operating failures. There was professional advice to avoid using the service lift, that connected to the kitchen, if possible. This was reiterated in subsequent staff and resident meetings. A professional safety check of that lift on 5 January 2017 did not clearly state that it was safe to use, although further explanation provided to us from the lift company stated that this was a technical matter and did not compromise people's safety. There was a record on 6 January 2017 of a staff member being trapped in that lift for a small period of time due to malfunction. As a result of our concerns with the effective maintenance of this lift, the registered manager acquired further professional input which resulted in a safety certificate being issued for that lift after our visits. However, without our intervention, we were not confident that sufficient professional maintenance would have occurred in a timely manner.

Some people told us they did not always experience there being enough staff. One person said, "In the mornings sometimes I'm waiting and waiting...I think they are short of staff." Other comments included, "Sometimes, when you ring for a carer they'll say 'I'll be five minutes but it's usually longer, twenty minutes" and "Too many of us and not enough staff in the evenings." A few people related this to night time, for example, "There's less staff at night so they don't come as quick if you press your buzzer. This can be frustrating but they do come and I know they are busy." One person summed it up well: "I think they do respond but they are over-stretched." A few relatives also reported that there was not always enough staff to consistently attend to people. One said, included, "They could do with having a few more staff and quicker responses to the call bells."

On our first day of visiting at 14:29, the call-bell system indicated that someone was waiting for over 13 minutes before staff attended to them. The registered manager subsequently explained that staff had not reset the call-bell system in this person's room correctly but that they had been attended to. However, our observations were that staff had not re-attended to this person given the ongoing call-bell activation. At around this time, someone else was asking for some indigestion medicine. They asked three different staff members across a period of 35 minutes before the person was provided with the medicine. Our observations supported what people were telling us.

Staffing rosters showed that the service was ordinarily providing ten care staff in the morning, eight from mid-afternoon, and four at night. This was in line with a dependency tool used for staffing calculations, and did not include the registered manager, deputy, or staff in other roles such as cleaners and activity staff. This suggested that rosters were showing reasonable staffing levels.

We checked a week's worth of recent call-bell records. These showed that people were usually responded to within five minutes. The registered manager told us she checked call-bells on occasion, but did not keep a record of this. This did not help to demonstrate that people were responded to promptly. After our visits, she emailed to say that she would start recording checks of these on a daily basis.

We recommend that the provider review the feedback about staffing availability so as to identify where improvements to people's experiences can be made.

The staff recruitment processes included interview questions to ensure the applicant could act safely and was caring. Staff files included identity checks, Disclosure and Barring Service (DBS) results, and at least two written references from appropriate people. However, there was no application form in place for one of the three new staff we checked, and no reference to an application form being in place on the checklist at the front of the staff member's file. There was therefore no written evidence that all appropriate references had

been acquired for them and that gaps in employment were explored, as references only covered their last three years of work. Copies of applicants' national training certificates (NVQs) were also not kept in two of the three cases, although the registered manager told us they were seen at interview. These shortfalls undermined the recruitment processes from being consistently safe and robust. The registered manager undertook to address this.

People's care files included overarching risk assessments, for matters such as skin integrity, falls, choking, and moving and handling. There were in-depth risk assessment and management plans where the level of risk was identified as significant. These were reviewed and updated on a monthly basis or sooner if needed, for example, where someone had repeated falls. When people moved into the service, the risk assessments were completed within a day, and an interim care plan was set up, which helped address safety concerns for them promptly.

Records showed that the service responded to accidents so as to minimise the risk of reoccurrence. Where these were about people falling, there were hourly monitoring records for the next 24 hours. Where people had repeated falls, referrals were made directly to the local falls clinic. After gaining their advice about the person's individual circumstances, changes were made with the person's consent where possible. For example, one person's footwear was changed and chair-raising equipment was quickly put in place.

Medicines were stored safely and appropriately. This included controlled drugs which required additional security, and medicines needing refrigeration. Only senior care staff administered medicines. They had all had received medicines training in the past year. They could describe to us the training and competency checks which they had to undergo before being given this task.

All medicines were available for people and staff could tell us how they obtained medicines in an emergency. Medicines were recorded accurately on the medication administration records (MAR). The MAR had a photo of each person to aid identification, and information about their allergies and how they liked to take their medicines. There were 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.

Senior care staff carried out audits of MARs after medicines rounds. There were records of any findings, which were communicated with the deputy manager and followed up immediately. Where needed, this was followed-up with the pharmacy or GP promptly in order ensure medicines were given to people as prescribed.

Some people were prescribed medicines to be taken 'when required.' Care plans did not always have enough personal detail of when to administer the medicine, which we saw rectified soon after we informed the registered manager. For people who could not communicate well, written pain scales were used to help staff decide when the pain-relief medicine was needed when.

Safeguarding information, about preventing and reporting abuse, was on display in the entrance area. Records showed there were reminders of safeguarding procedures within meetings for staff and people using the service. Training records showed that staff had up-to-date safeguarding training, and that everyone working at the service had to pass this training module. Staff we spoke with knew signs of abuse and to report any concerns to the management team. The registered manager told us there had been no safeguarding alerts for over six months. She explained two cases that were previously raised by the service, which demonstrated that appropriate referrals were made to the local authority.

People told us the service was kept clean. One person said, "The rooms are cleaned every day." Relatives

told us that the environment was very clean and inviting at all times. We saw this to be the case, and that staff sanitised their hands frequently and especially when coming in and out of people's rooms. The service had hand-sanitiser dispensers discreetly placed around the premises. There were systems in place for the safe management of clinical waste. We also noted that the Food Standards Agency's most recent rating for the service was five-star, the highest available.

Good

Is the service effective?

Our findings

People told us they liked the service. Comments included, "I'm very happy here", "I can't fault anything here" and "It's excellent." Relatives felt the service was very effective, one saying, "I can't speak highly enough of the service." They stressed that staff were very good at their jobs.

People using the service provided many comments on meals with quite a wide range of views expressed. The following quotes summarise: "The food is excellent", "It's good, but it's not like home", "It's not bad, but then again it's not that good", "I really don't like the food" and "They've tried very hard with chefs...they're doing their best." However, relatives fedback positively about the food. One relative stated, "My mother has a pretty good appetite and they make sure she has plenty to eat. She has never complained of being hungry, if anything, too full!" Another said of their family member, "She has even put on weight since being here." A third relative told us, "The food is of a good standard and a good variety is on offer."

Records showed there had been much effort to improve on the food quality and people's satisfaction with the service provided by the hired-in catering company. This followed a meeting with the company at which a number of people using the service presented their views. One person ultimately took the company's representatives to a local baker to help ensure the correct bread was served. Better snacks at 20:00 were established, and a permanent head chef had since been recruited who was starting to meet with people on a regular basis. Copies of relevant sections of residents' meeting minutes were being shared with the catering company. Whilst people still had some mixed views on food and drink, service quality had clearly improved in recent months through feedback from people using the service.

People seemed to be enjoying the choice of home-cooked meals at the lunch we saw, and there were enough staff to assist people who needed support to eat. One relative confirmed this, saying it was "calm at lunchtimes." One larger table was designated solely for people who needed assistance with eating. People who chose to dine in their rooms had their meals delivered under metal lids, to help ensure meals stayed warm.

Records and staff feedback showed that the service monitored people's weight regularly, and took action if concerning weight loss was identified. This included through fortified diets and referrals to the community dietitian for additional support. Kitchen staff had information on people's dietary needs including a summary on the needs of each person with diabetic or fortified diet needs.

People generally received good healthcare support both within the service and through liaison with community healthcare professionals who all fedback very positively. Their comments included "very impressive", "nothing is too much trouble" and "I have only praise for the staff who work at Sydmar Lodge." They all felt the service worked in cooperation with them, for example, in following their guidance and helping people to be ready for their visits.

People reported that the service got their GP quickly when needed, and we saw this to be the case. Records and feedback showed that the service was able to acquire community healthcare support for a variety of

matters. This included dentists, audiologists, and district nurses. Staff reported using the local 'Rapid Response' team in support of better healthcare where support was needed but not for hospital admission. The service had helped one person to quickly acquire physiotherapy support on their return from hospital. This was helping the person's ongoing recovery.

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 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 told us there were no such conditions, and we did not see any in people's files. DoLS were in place, or applied for, for relevant people. The registered manager used a tracking matrix to make sure that relevant applications had been made, and that authorisations were renewed where needed.

People's care files included risk assessments in respect of restrictions the service placed on them, including for the use of door codes around the service. Where people were judged as safe, and in line with documented MCA processes, people were told of the key codes. Where not, capacity assessments for understanding the proposed restriction took place, followed by recorded best interest decisions if appropriate.

Staff were seen to gain consent from people where possible for care, and knew about gaining consent. One staff member told us of a person who sometimes resisted being hoisted. They knew that it was important to talk with the person about things that calmed them, and that they were not to hoist the person until their behaviour indicated acceptance of the manoeuvre.

The provider monitored staff training. In terms of mandatory training, the monitoring tool showed 92% compliance, meaning most staff had passed tests on training considered essential for their roles. This included first aid, health and safety and food hygiene. It was encouraging that dementia training was considered mandatory at this service, and that there was a 100% pass rate.

Records and staff feedback showed the service was implementing further face-to-face dementia training. The training was developed by a community healthcare improvement organisation and was being provided through the local authority. Its aim included for staff to identify people showing signs of dementia, and make a referral to the GP so as to enable better support for the person. Staff also reported that it helped to empathise with the person, and guided on good and poor practice. We were also told of recent training on the effective use of inhalers.

Staff and the registered manager told us of recent 'Significant Seven' training from the local authority's Quality in Care Homes team about early signs of the people's needs increasing. Resources from the training were on clear display in the staff office, to help remind them of key points.

Records showed that new staff were properly inducted into their roles. The service worked towards new staff completing the national Care Certificate standards. This included competency observation and assessment

processes for a range of considerations of people's safety and welfare. Rosters showed that new staff worked a number of shifts shadowing established staff before working alone.

Staff reported that they received good support for their roles, and regular supervision meetings, which records confirmed. Records indicated that the development of individualised care plans was a key feature in recent supervisions.

Good

Is the service caring?

Our findings

People reported that staff were very caring. One person told us, "They've very nice staff." Other comments included, "They listen to you and I think they care", "They're so good, it's a terrible job" and "They work jolly hard. I would not like to do their job."

Relatives provided similar comments. One relative said, "My mother always smells really clean and fresh and I can visit at any time." Other comments included, "The care is good here, it's picked up a lot over the past few months", "Brilliant care, patient staff" and "The carers are all very kind to the residents and seem to show the empathy required to do this challenging job well."

We found numerous examples of how the service was caring. We saw staff interacting with people in a friendly and caring manner, for example, singing songs that people liked or joining in with people who liked to joke with them. Both the registered manager and the deputy attended to people in distress whilst talking with us. Staff were similarly attentive, showing concern for people. Senior staff gave people medicines in a caring manner, allowing people time to understand what they were doing. Attention was paid to supporting people with their appearance where needed, and people were generally well-dressed. People benefitted from the regular attendance of a hairdresser and had a designated room for their service.

During recruitment interviews, applicants were asked many questions about treating people well and enabling a better quality of life. Records also showed that applicants were additionally interviewed by someone using the service, a new process arising from the provider's involvement and inclusion audit. Feedback from the person, and observations of how the applicant interacted, helped inform recruitment decisions. This all helped assure us that the service recruited caring staff.

The service assessed the capability with which new staff interacted with people and promoted dignity. This was through a set of specific observations of such things as body language, facial expression, warmth of interaction, and how the person interacted with people who were non-verbal. There was also emphasis on how they enabled people to communicate well through ensuring hearing aids worked and glasses were clean. One person specifically told us, "They clean your glasses." Feedback about new staff was also sought from people using the service. This process helped to develop new staff and ensure that people were communicated with effectively and respectfully.

The service undertook a 'Dignity Action Day' recently. This included focus on people who choose not to go out, bringing them the afternoon tea and scones that many others enjoyed in the community through the service's regular trips out. An activity coordinator explained, "We try to make sure no-one is left out." There was also a discussion about what people though dignity meant, with answers attached to a 'Digni-tree.'

We were shown numerous written compliments about the service. One relative was grateful for the support of their family member's return from hospital at a very late hour. Another relative praised the different ways the service tried to include their family member despite the person's hearing loss. Feedback from families of people who had passed tended to emphasise how kind the staff were and making it, for example, "Mum's

home." Staff were represented at people's funerals which family members appreciated. With permission, detailed obituaries about people were written in the service's newsletter. This all showed strength of feeling for people who had passed.

People reported that they were treated with respect. One person told us, "They are always very caring and yes they do respect my dignity. I am very old fashioned and they are careful to shut the door when they are changing me. They don't always knock before they come in, but they always call out before they enter." Relatives spoke similarly to us, for example, "The staff are encouraging and treat her like a human person."

People felt they were encouraged to be as independent as possible. Comments included, "They're well-meaning and good at supporting people" and "They let me wash myself." Some people dressed themselves without help daily. Where agreeable, staff supported people to go shopping, for example, for food and clothes, which particularly benefited one person who did not join in with many activities.

Relatives told us that staff always engaged well with people. One said, "It is extremely impressive and a great feat that there has hardly been any change of staff…. from the resident's point of view having familiar faces around who understand their needs is very important and comforting." We saw a lot of interaction between staff and people using the service throughout the day. Many people were familiar with the team of staff and knew their names.

We noted that there were no agency staff working at the service, which one person using the service confirmed as correct. A staff member told us this had been the case for about a year. Many staff had been working at the service for a number of years. This all helped to enable people's needs and preferences to be understood and met, and positive, caring relationships to develop.

Most people who understood care planning reported that they left that to their family to address, for example, "My family deal with my care." A few people told us they were involved, such as, "Yes, staff do talk to me about my care." Relatives felt they were fully involved, consulted and notified about care plans and any changes to be made. One relative told us, "I feel totally involved in my mother's care plan; she doesn't need to worry herself about that side of things."

The service promoted a Jewish ethos but welcomed people of all faiths. The registered manager told us, "All food is prepared in our kosher kitchens. The local Rabbi visits regularly and is always on hand for support and discussions. He attends every Friday evening for Kiddush and the festivals." Photos showed that people were very involved in an annual Challah Make and Bake event. Mitzvah Day, a national Jewish initiative to promote people of all faiths coming together to build more cohesive neighbourhoods, was also celebrated with many local visitors. Relatives fedback positively about how Jewish customs were upheld.

The provider did not specialise in the care of Jewish people, and so had no specific training for staff in that respect. The registered manager told us that to help educate staff on Jewish culture and traditions, one staff member was leading short sessions on different aspects of Judaism. Staff meeting records showed that this included detailed handouts.

People told us the environment was comfortable. One person said, "It's warm enough, but they give you a cardigan if you're cold." People generally told us their rooms were welcoming. One person said, "I love my room. I've just had new curtains and they say they will be decorating it soon. I don't know when but that will be nice." Another person commented, "It's a fantastic room, good as a hotel!" Staff told us that people were involved in choosing colours for an ongoing program of refurbishment of their rooms.

Good

Is the service responsive?

Our findings

People told us that staff were responsive. One person said, "They would deal with issues", another that staff are "attentive." Relatives told us the service was very responsive. One relative said, "Any problems they deal with straight away." Another told us, "They let me know if her make-up is running low." A third gave examples of how the registered manager and other staff tried to encourage their family member to eat and enjoy companionship. We saw that catering staff served refreshments and snacks in a friendly manner and knew the likes and dislikes of each person.

Some relatives told us of how the service had improved their family member's quality of life. One relative explained how their family member now got dressed in the morning where before they did not bother. Others told us of family members gaining weight which they viewed as positive. A compliment card and a photo showed that one person had been supported to walk again following some complex healthcare issues.

The service provided a wide range of activities that tried to suit people's preferences. An activities sheet listed a full programme for the week and was a good mixture of outside entertainers and in-house activities. The activities sheet was available in the foyer for visitors to see and some people showed us that they had copies of it.

During our visits we saw short exercise sessions provided in the mornings that many people joined in with, in line with a national exercise programme that the service had signed up with. Records and activity plans showed that the exercises took place on most days, followed by another activity the same morning. A live singer provided an engaging afternoon performance to a well-attended audience including some relatives. Songs included wartime tunes that some people recognised and sang along with, and one song sung in Hebrew. At times, people got up to dance. People with greater needs attended and were supported by staff.

People generally commented positively about activity provision: "I enjoy the sing-a-longs and the entertainers that visit are very good", "There's quizzes, a choir, art, lectures and films" and that those who run the activities "are doing well. I go to the choir...it's a jolly thing to do...we sing songs from musicals."

Relatives told us that the activities were all very good and enjoyable. One explained that there was "huge effort to lay on age-appropriate activities and to provide the residents with as much stimulation as possible both physically (through exercise classes) and mentally, including regular outings especially in the summer months."

We saw photos and reports of recent events and activities at the service. These included people growing and harvesting tomatoes in the garden during the summer, an opera performance, a fireworks display for Bonfire Night, a celebration of Burns Night through food and poetry, and many volunteers who provide arts and crafts, quizzes and musical entertainment. An activities coordinator told us of memory-box sessions for people to discuss and reminisce. They said that one that people most enjoyed was when people brought along photos of their weddings.

There were regular bridge evenings, and a now-established choir called The Sydmar Singers who practiced twice weekly and attracted large crowds for their recitals. A large summer party took place with a Hawaiian theme. There were even videos of some of the events at the service, including people using the service and staff taking part in a recent internet trend called The Mannequin Challenge where everyone was filmed stationary. An activities coordinator told us that videos and photos were updated weekly onto the display screen in the entrance hall. This reminded people of recent activities, and showed relatives what had been happening recently.

Through the service's minibus, there were weekly trips out for six people including one person using a wheelchair. Venues included shops, museums, hotels, arts centres and cafes based on people's collective choices and knowledge of the local area. These occasionally went further, for example, for people to see the festive decorations and displays around Central London during December. As one relative put it, "Every other Wednesday she goes out for tea."

The service enabled people to maintain and develop connections with the local community. Everyone reported that their visitors were made very welcome. Photos and feedback showed that the service welcomed visits from local schools and nurseries. The service supported one person to attend the local synagogue regularly.

Remembrance Sunday was respected, and the service supported one person to attend the Association of Jewish Ex-Servicemen and Women's Annual Remembrance Ceremony and Parade in central London.

People were supported where possible to vote in recent elections, along with discussion events taking place in the service on the options and outcomes. Representatives of local parties visited the service as part of this process.

One person told us, "There's a monthly residents' meetings. Things get brought-up and there's a 50/50 chance of getting things resolved." The registered manager told us that a microphone was used, to ensure that those with quieter voices had a turn and were heard. Minutes of the last meeting, for December 2016, provided an update on matters from the previous meeting, discussions on any areas of concern, and updates on service matters such as new staff and activities. Meeting minutes provided updates on matters arising, which helped to assure that people's views were taken seriously and acted on. As the regional director stated, people using the service "help shape the service." We also noted that significant feedback about food quality had resulted in a number of people using the service meeting with the outsourced company who ran that aspect of the service, further details of which are under the Effective question.

Most people and their relatives felt confident that if they had reason to complain, it would be dealt with properly and in a timely manner. The registered manager told us she operated an 'open-door' policy, and that suggestions could also be placed in the comments box between her office and the lounge. The service's complaints procedure was on display near the lounge. People were reminded of the procedure at residents' meetings, and that matters could be escalated to the new regional director if needed. Complaints were also discussed at staff meetings, to ensure staff were aware of current concerns and how they were being addressed.

The service's complaints records included matters that were raised informally, for example, in person and by email. Matters were investigated and, where appropriate, addressed. Where possible, the complainant was asked to sign that they were satisfied with the response. There was oversight of the complaints, to help identify trends and ensure timely responses.

Records and staff feedback indicated a lot of work to review and improve on people's care plans. This included for personalisation, and ensuring that evaluations took place regularly. This followed the provider identifying shortfalls in these respects at a service-wide audit. There had been some training from the local authority to assist with this, along with workshops for staff run by the regional director. The registered manager explained that staff at all levels were involved. They found that plans often did not match the care that people wanted and were receiving in practice. Therefore, care plans needed improving, and all staff had to take greater ownership of them. Staff confirmed this, adding that they sat with people and their families to ask what they wanted and to agree care plans. The registered manager was checking progress with this updating process regularly, signing off completed work.

We found that people's care plans were, in the main, personalised and up-to-date. Plans included reference to people's preferences such as what they liked to wear. A 'This is me' document at the start of people's file helped clarify people's preferences and how their life histories might influence their current care needs. Staff reported that one person with dementia did not like to be touched. Therefore their care plan was rewritten to minimise this whilst still providing necessary care. We saw another plan that guided staff very particularly and respectfully on how to work with the person when they expressed signs of frustration. Reviews of care took place on a monthly basis and summarised relevant aspects of the person's health and well-being.

Requires Improvement

Is the service well-led?

Our findings

There was a lot of positive feedback about the new registered manager. One person told us, "The new manager is very good indeed. She's got time for you; she's decorated rooms and you can talk to this new manager. It's very good now." Another person said, "She does the job very well." Some people could point out the registered manager to us, which helped assure us that she was well-known to people using the service.

Relatives told us the service was very well led, and had improved, or "tightened-up" as one relative put it, under the leadership of the new manager. Another relative said of the manager and deputy, "They are both excellent at what they do, making every effort to ensure that the staff deliver a high standard of care with kindness and empathy." We saw instances of this occurring.

We noted that the service was full, in comparison to previous inspections, which we understood to be from increased word-of-mouth recommendations. Similarly, the service's rating on a national review website had increased significantly since the previous inspection.

However, despite these improvements, we identified that the service was not consistently well-led. We found some concerns around how the service ensured that people received high quality care. This was because there were some weaknesses in terms of service-wide communication and ensuring accurate care records.

One person's file contained three recent healthcare professional visit outcomes. We asked senior staff about actions resulting from this, as we could not see records showing that two of the actions had been addressed. Additionally, the most recent monthly review on the person's file restated the health professional advice of five weeks previous without indicating that the actions needed after two weeks had occurred. We brought this to the registered manager's attention, who subsequently confirmed that one matter was not addressed whilst the other had been but there was no documentation to confirm it.

A meaningful summary of each person's care was ordinarily written four times a day. However, for two people who had moved into the service on respite recently, we found that their care records were incomplete. There were many occasions when parts of their care across the day had not been recorded. This included across the whole day for one person on 24 and 25 February, then omissions of the afternoon and evening for them on 26 and 27 February. The other person's records omitted day and night entries on 18 and 22 February and were incomplete on all days in-between. We brought this to the registered manager's attention. She told us that senior staff would now be required to check at the end of each day that these care records had been completed, as already occurring for food and fluid charts. We were subsequently provided with copies of documents showing how this action had been implemented.

Records in support of the smooth running of the service were also incomplete. A handover took place between incoming and outgoing staff at the start and the end of the day. We asked to see records of the handover sheets used for the week up until our first visit. Only two were in the designated file. Three others

were subsequently found in the staff office plus one in the manager's office, but one other could not be located at all.

The level of detail in these handover sheets was not consistently accurate. The sheets provided a space for any essential information about each person to be recorded, such as there was new medicines to be aware of, if the person was ill, or if there had been an accident or incident. However, one sheet stated that one person had a choking incident. When we checked the person's care records for that day, there was no such record. The registered manager spoke with staff and established that the person was coughing a lot after lunch that day, rather than choking. This, however, was not recorded in their care records. Both records about this person were therefore inaccurate.

We saw that the staff communication book was seldom used. There were instead sometimes loose pieces of paper placed prominently in the staff office to remind other staff, including about weighing people or asking GPs to visit. Additionally, the main desk in the office was not tidy at all and it had many loose pieces of paper on it at our first visit. In contrast, people's care files were kept in an orderly manner. We brought these matters to the attention of the registered manager, who subsequently sent us evidence of the staff communication book now being used to convey important information about changes to individual's care. We were also shown that handover sheets now included relevant information about each person, and so were being used more effectively to help convey any ongoing care concerns about each person.

At our first visit, staff told us of someone having a fall the previous day and damaging someone else's walking frame which we saw was now taken out of use. At our second visit, the accident record for that fall could not be found despite the registered manager telling us that she had seen it. The fire safety records included that someone using the service had accidentally set off the fire alarm earlier in the month, but there was no incident record of this. Neither occurrence was referred to within the service's accident and incident log and had not been added to the provider's online monitoring system. Scrutiny of significant events at the service was not therefore comprehensive, as we could not be assured that the provider was made aware of all accidents and incidents. The registered manager undertook to address these points, and subsequently provided evidence of this.

Our findings in respect of some premises and equipment maintenance matters, as highlighted under the Safe section, demonstrated ineffective auditing of the service. The provider's October 2016 health and safety audit confirmed that a professional Legionella check took place across the service in July 2016. However, despite the professional check highlighting many concerns, some for immediate action, the provider's audit did not identify that action had not been taken to address concerns.

The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff reported that the felt very supported by the registered manager and the deputy as they were approachable, they helped out, and they encouraged staff development. One staff member reported that the registered manager had "turned it around" compared to a year ago, explaining that there was better understanding of roles and responsibilities as the registered manager "is on the floor with you." Another said the registered manager was "the best we've had." A third said, "You can tell them anything."

The provider had structures for encouraging staff development, in line with their stated values, which the service was using. All grades of staff were encouraged to attend specialist courses that enabled them to provide face-to-face training in the service for other staff. Attendees also filled out a review form for the course, to check how well course objectives were met and to plan how they would implement the learning.

Records showed that this occurred recently for dementia care. Staff reported improved confidence and skills in supporting people, and reflected that it helped that training was provided by familiar team members.

Staff meetings occurred every other month as a means of updating and discussing with staff about relevant matters in the service, and reminding them of service standards. Staff meeting records showed that the provider's core values were discussed along with ensuring staff knew how to whistle-blow if they believed inappropriate working practices were occurring. A poster to that effect was clearly displayed in the staff office.

The provider's quality team undertook a service-wide audit in September 2016. A number of areas for improvement were identified. A further comprehensive audit took place in early January 2017 where significant improvements were noted. This included for individualised care planning, nutrition and hydration, and service governance.

The service undertook numerous audits to ensure that procedures were working effectively and in people's best interests. An example was the pressure care audit that the registered manager undertook in August 2016. This identified a number of areas for improvement, for which we saw records confirming that actions had been taken. Other audits included for infection control, medicines management, care plans, food and mealtimes, and laundry. The provider had set up templates for all these processes, by which to monitor all outcomes online.

The provider commissioned a market research organisation to conduct an independent survey of people using the service between August and October 2016. Results of this, based on feedback from 14 people, established that the service was experienced as about average compared to nationwide market research. We noted, however, that everyone said they were happy living at the service and that they were happy with overall standards, which was above national averages.

The registered manager told us that viewpoint surveys had been recently designed and sent out to people's relatives and staff. Overall results had not yet been collated, but returns were checked individually and actions taken where possible. Survey results were shared with us. All provided significantly positive feedback, though some made suggestions for additional improvements. We saw that additional footstools had been provided as a result, for example.

When anyone was seriously injured such as due to a fall, the service took this seriously, investigated circumstances, and learnt from findings. They followed Duty of Candour processes properly. These are relatively new requirements placed on care services, to act in an open and transparent manner including in respect of serious accidents. They sent a letter to the person involved in the accident of their representative, to provide an account of the accident and explain what further enquiries were being made, and to express regret. A further letter concluded the investigation, the report of which was shared. They also met with the person or their representatives where possible.

The registered manager told us of recent redecoration of the first floor lounge that new had a Hollywood theme through a number of large pictures of past entertainment stars. There was ongoing redecoration of people's rooms, and a new bath was being fitted to the second floor during our visits. However, we noted that the last infection control audit we were sent stated that carpets were stained and required replacing. Carpets outside the dining area did not present well. The regional director told us that these would be replaced within the next year's budget.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons were not ensuring that, in respect of the safe care of service users including through addressing risks relating to Legionella, the premises were used in a safe way. Regulation 12(1)(2)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effectively operated to ensure compliance with the Fundamental Standards. This included failure to: • assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others; • maintain securely an accurate, complete and contemporaneous record in respect of each service user; Regulation 17(1)(2)(b)(c)