Sunridge Housing Association Limited

Sunridge Court

Inspection report

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11 December 2017

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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

This inspection took place on 23 and 27 November and 11 December 2017. Sunridge Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Sunridge Court accommodates 43 people in one purpose built building and caters specifically for the Jewish community. The home is over three floors, with the top floor being used for training purposes. There is a large living room with a sun lounge and people have access to a large well-kept garden. At the time of the inspection there were 40 people living in the home.

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.

At the last inspection on 22 and 28 January 2016 we asked the provider to take action to make improvements to how individual risks to people using the service were documented. This included guidance provided to staff to help minimise the known risks to people that they worked with. We also asked the provider to take action around providing staff with regular supervision and appraisal and to ensure that people's care was documented and delivered in line with The Mental Capacity Act 2005 (MCA). At this inspection we found that these actions had been completed.

We have made a recommendation about the safe management and documentation of medicines.

Risk assessments gave staff detailed guidance and ensured that risks were mitigated against in the least restrictive way. Risk assessments were reviewed and updated regularly.

Staff understood what safeguarding was and were aware of how to report any concerns if they had them.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff had received training in infection control and were aware of how to control and prevent infection.

Staff received regular, effective supervision and appraisal.

There were individualised care plans written from the point of view of the people that were supported. Care plans were detailed and provided enough information for staff to support people. Care plans were regularly reviewed and updated immediately if changes occurred.

People and relatives were encouraged to help plan end of life care in a tailored way. Staff were compassionate regarding caring for people at the end of their lives.

The home recognised that stimulation and enjoyment were essential to people's wellbeing. There was a wide variety of activities that people could choose to take part in. people were supported and encouraged to access the community and stay in contact with relatives and friends.

People were supported to communicate using technology and training for people around using the internet had been provided.

Staff, people and relatives were positive about the culture of the home and the management.

Audits were carried out across the service on a regular basis that looked at things like, medicines management, health and safety and the quality of care. Surveys were completed with people who used the service and their relatives. Where issues or concerns were identified, the manager used this as an opportunity for change to improve care for people.

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. Whilst medicines were generally managed well, there were some issues around documentation and recording. We have made a recommendation about this for the provider to improve in this area.

Staff were able to tell us how they could recognise abuse and knew how to report it appropriately. People were actively encouraged and supported to report concerns.

There were sufficient staff to ensure people's needs were met.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were minimised.

The home had a good understanding of infection control and staff used personal protective equipment to ensure safe care.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role.

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS).

Staff received regular supervision and appraisals. People were supported by staff who regularly reviewed their working practices.

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing. People were supported to access private healthcare if they wished.

People were supported to have enough to eat and drink so that their dietary needs were met.

Is the service caring?

Good

The service was caring. People were supported in a kind and caring way and staff understood individual's needs.

We observed that people were treated with respect and staff maintained privacy and dignity. Staff treated people kindly and were patient and kind in their interactions.

People were encouraged to have input into their care.

Is the service responsive?

Good

The service was responsive. People's care was person centred and planned in collaboration with them and where requested, their relative's.

Staff were knowledgeable about people's individual support needs, their interests and preferences.

People were encouraged to be as independent as possible, be part of the community and maintain relationships.

People knew how to make a complaint. There was an appropriate complaints procedure in place. The home responded appropriately to any complaints.

End of life care was compassionate and planned according to people and relatives wishes.

Is the service well-led?

Good

The service was well led. There was good staff morale and guidance from management.

The home had a positive open culture that encouraged learning.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

There were systems in place to ensure learning and sharing best practice which all staff were involved in.

Sunridge Court

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 27 November and 11 December 2017. The inspection was carried out by one adult social care inspector 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. One expert by experience attended the inspection and spoke with people to gain their views and opinions of the home. The second expert by experience supported this inspection by carrying out telephone calls to people's relatives following the inspection.

Following the last inspection we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe and effective to at least good. This included information around safe medicines management, personal risk assessments for people living at Sunridge court, ensuring that the principles of the Mental Capacity Act 2005 (MCA) were being followed when working with vulnerable adults and supporting staff around supervision and appraisal to ensure that staff were adequately supported.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We also looked at safeguarding notifications that the provider had sent to us. Providers are required by law to inform CQC of any safeguarding issues within their service.

We used information the provider sent us on 6 March 2017 in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with four staff including the registered manager, the executive director, two assistant managers and 15 people that were living at the home. We also spoke with a healthcare

professional and one relative that were visiting the home at the time of the inspection. We looked at six care records and risk assessments, eight staff files, and other paperwork related to the management of the service including staff training, quality assurance and rota systems. Following the inspection we spoke with eight relatives and four care staff.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 22 and 28 January 2016 we found that risk assessments did not always provide staff with adequate information on how to minimise identified risks to people living in the home. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found that the provider had addressed this issue.

Risk assessments were person centred and detailed focusing on what the risk to the person's well-being was and how staff could work effectively with the known risk. Personalised risk assessments were seen for issues including, the use of bedside rails, falls, using the stairs, going out alone and behaviour that challenged. Health conditions were explained, symptoms of ill-health and relapse were detailed and action staff should take was clearly documented.

At our last inspection we found that medicines were not always managed safely. Stocks of controlled drugs (CD) were not always recorded accurately. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations. There was no person specific guidance in place for people receiving 'as needed' (PRN) medicines. 'As needed' medicines are medicines that are prescribed to people and given when required. This can include medicines that help people when they become anxious or are in pain. We also found that whilst medicines management audits had been carried out monthly, action points resulting from these audits had not been implemented. At this inspection we found that the provider had addressed these issues.

Medicines were stored securely in medicines trolleys and cupboards in a special medicines room which was clean and spacious. There were two CD cabinets attached to the wall in the medicines room. Stock and administration records for controlled drugs (CD) were accurate and we saw that all CD's were being recorded in the CD register and witnessed by two members of staff. Monthly audits of CD stock were being completed.

PRN protocols were available for people to support the use of medicines prescribed 'as needed'. We observed that staff did offer medicines prescribed as 'as needed' to people during lunch time medicine administration. However, we saw two people who were prescribed PRN paracetamol tablets but did not have accompanying PRN protocols. In one case, the care worker said that it was usual to give the paracetamol regularly because the resident was 'always in pain'. The provider's medicines policy stated 'Where a resident is prescribed 'When Required' medication, a specific plan for administering this 'When Required' must be documented in the medication care records'. Following the inspection the executive director sent us the PRN protocols for the two people receiving PRN paracetamol.

Staff recorded the administration of creams on two separate forms; MAR charts and topical MAR charts. However, we saw inconsistency in the records where staff were signing one or both forms. Therefore there was no assurance that people were receiving their topical preparations correctly. We raised this with the manager at the time of the inspection. On the second day of the inspection the registered manager showed

us that topical creams had been removed from MAR charts and any topical medicines were now recorded on a topical MAR chart only. We saw that all people receiving topical medicines had individual MAR charts that were now located in their bedrooms. This included detail about where the topical medicine was to be applied. Staff that we spoke with were aware of the new procedure.

Staff told us that people receiving medicines that needed regular blood monitoring and dose changes were appropriately monitored. We saw clear records of the medicine warfarin, a medicine used to thin the blood, being monitored. Staff told us that the GP visited weekly and we saw documented evidence that medicines were reviewed during these visits.

People who were able and wished to do so were supported to manage their own medicines. We saw documented evidence of self-administration assessments for people that were managing their medicines. A relative said, "If she required it [help], they do offer. She is self-medicating."

Staff described a comprehensive competency based training process that was undertaken before being signed off to administer medicines. However, the associated documentation did not provide a clear summary of all the training that staff had undergone. We raised this with the manager at the time of the inspection who told us that new competency assessment documentation was being put in place. This was more narrative and would describe what the competency assessment looked at rather than a tick box format. Following the inspection the executive director sent us a copy of the new format competency assessment form. We also spoke with staff following the inspection who were able to describe what the competency assessment entailed and told us that they felt that the assessment ensured that they were competent to administer medicines. Staff commented, "After medication training they do a competency assessment. Observed how I did it on a medications round and that everything was right" and "It's [competency assessment] all about the medication, about the person and double checking everything and concentrating on ensuring it is done right. We can only administer once the competency assessment has been done."

At our last inspection we also found that minimum and maximum fridge temperatures of the fridge where specific medicines were kept were not recorded. On a number of occasions the recorded temperatures were outside the recommended range but no action had been taken. At this inspection we found that the maximum fridge temperature had continuously been recorded as 17°c since August 2017. This suggested that staff were not resetting the fridge thermometer on a daily basis. We discussed this with staff and found they were not aware that they were supposed to reset the thermometers daily. In addition, they had not sought advice for the high temperature reading of 17°c. Audits conducted by the local pharmacy who supply medicines to the home had not identified any issues with regards to temperature monitoring. Actual fridge temperatures were within the correct limits. We raised this with the registered manager at the time of the inspection who said that they would get the local pharmacy to come in and re-train staff on ensuring fridge temperatures were recorded correctly.

The Registered Manager told us medicines incidents were not formally recorded. Another member of staff said that if there was a medicines incident it would be reported directly to a manager. However, the Medicines Policy described a formal process for recording and investigating medicines incidents. Staff that we spoke with understood the procedure for reporting any medicines errors and said that these were always discussed and investigated.

Whilst medicines were generally well managed, there were some issues relating to training and staff understanding of medicines storage and correct documentation.

We recommend that the provider seeks guidance from a reputable source around management of medicines within a care home setting.

Relatives were positive about the way that people's medicines were managed by the home. Comments included, "Yes it's provided by the doctor and they monitor it", "Oh yes, definitely [receives medicines] at all times. It's very controlled. They apply it at regular scheduled times. Occasionally she has to wait, but nothing major. Certainly what is expected" and "Yes, they manage medication and I've seen the records and I'm happy." Other relatives confirmed that their relative managed their own medicines but said that the home offered to help with medicines if necessary.

At our last inspection we found that staff recruitment was not always safe. We found that for two staff there were no references on file, interview assessments had not been documented in staff files in line with the provider's recruitment policy. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found that the provider had addressed this issue.

The service followed safe recruitment practices. We looked at eight staff files which showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role. Where a staff member was new, we saw that interview assessments were on file. Since the last inspection a staff file audit form had been put in place that checked all required documentation was present. The recruitment policy had been updated since the last inspection and the provider now re-applied for staff members' criminal record checks every three years in line with best practice. Where volunteers applied to work at the home, they underwent interviews, criminal records checks and references were obtained prior to starting as a volunteer.

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. Staff comments about safeguarding included, "Any abuse or neglect, we have to protect them from things like financial abuse, physical abuse and so on. We would report to the manager about that. We can contact CQC if necessary. It's our job to always report." Staff understood what whistleblowing was and knew how to report concerns if necessary.

People told us that they felt safe living at Sunridge Court. People told us, "Safe? Oh, yes. The staff are wonderful", "They [staff] check on me and stay overnight. It's wonderful" and "If you need help they will come. Anything they are not sure of they will get an ambulance." Relative's comments included, "I have no reason to think otherwise [about safety]. Yeah, she has all the equipment to press buttons, so there's no reason for me to think otherwise", "I certainly do [feel relative is safe] because anytime there's been any sort of crisis they've always been there. I've never had any doubt they won't be available" and "Yes, she is safe. The care she receives I find is first class and the main thing is she is happy and safe. She's comfortable. Everything I've seen is first class. She's completely of sound mind. If there is something wrong she's quite capable of complaining."

There were sufficient staff to allow person centred care. We asked the executive director how staffing levels were determined to ensure that the needs of people were met. The executive director told us and we saw that each person had a dependency analysis completed each month. However, this was not used to guide staffing levels but did give guidance on when people's needs changed. The executive director told us that, "We run on a one to five ratio, predominantly based on the number of residents. If we know extra staffing is

needed we will put in extra staff. For example, on a Wednesday we have a GP round so we always put on extra." Relatives and people that we spoke with felt there were enough staff on duty both during the day and at night time to ensure people's needs were met.

The home assessed people's potential for developing pressure ulcers by using the Waterlow scale. The Waterlow scale is a specific way of estimating the risk to an individual of developing a pressure ulcer. If an individual is classed as medium or high risk their pressure mattress suitability is re-assessed. Records showed that Waterlow assessments were completed each month for people that were at risk. Where a person had been identified and assessed as high risk, they had been referred for further assessment for appropriate equipment to a tissue viability nurse and we saw that the appropriate equipment had been put in place.

Accidents and incidents were documented. The incident itself and the immediate action had been recorded. Incident reports also included the details of any follow-up action and people's care plans were updated if necessary.

The home ensured that staff understood infection control and how to protect people from infection. Staff had been trained in infection control and the service ensured adequate supplies of personal protective equipment (PPE) such as gloves, aprons and shoe covers were available. Staff told us that they always had access to PPE. We observed staff using PPE throughout the inspection.

All bedrooms and bathrooms had a call bell system in case people required help. We saw in one person's care plan that they were unable to use the standard call bell that were provided for people in their rooms due to a disability. The home had purchased a large call bell that ensured that the person would always be able to call for help if necessary. This showed that the home treated people in a person centred way and took individual needs into account.

The home had up to date maintenance checks for gas, electrical installation and fire equipment. Staff understood how to report any maintenance issues regarding the building.

Good

Is the service effective?

Our findings

At our last inspection we found that staff did not receive regular supervision and no staff had received an appraisal. The executive director told us following the inspection that they had developed a supervision and appraisal matrix and would aim to conduct supervision every two months. This was evidenced in the updated action plan submitted by the provider. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found that the provider had addressed this issue.

Staff told us and records confirmed they were supported through regular supervisions. We saw that new staff received monthly supervision until the end of their probationary period. Following this staff received supervision every two months. A staff member said, "Yes, we do supervision. When you start it's once every month during your probation and then once every two months. We can raise concerns and it's when the manager can tell you how you are working." All staff that had been working at the home for more than a year had received an annual appraisal.

Staff received a comprehensive induction when they started to work at the home. This included, getting to know the people who lived at the home, understanding policies and procedures as well as mandatory training such as medicines, safeguarding and manual handling. The executive director told us, "All staff have a minimum of two weeks shadowing with a senior carer. They then have a meeting with the registered manager to decide if more shadowing is necessary and will continue to shadow until we and they are satisfied that competencies have been met."

Records showed and staff told us that they were provided with training to enable them to carry out their role. Training records showed when staff had completed training and when they needed to refresh specific training such as, safeguarding, MCA, manual handling and health and safety. The executive director told us, and we saw that, "All mandatory training is completed in April and May with updates in October. There are specific courses done for individuals if they start before or after these times." On the first day of the inspection there was a planned staff training morning around health and safety. Staff also received training in specialist areas such as dementia care which looked at how to support people living with dementia in a person centred way.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our last inspection we found that consent to care and treatment was not sought in line with legislation and guidance. We found that for one person their 'Do Not Attempt Resuscitation' (DNAR) form indicated that they did not have capacity to understand resuscitation. However, they did not have a mental capacity assessment to assess the person's capacity before this decision was made on their behalf. Mental health assessments seen on file were incomplete with most sections blank. Care plans were not signed by people using the service. At this inspection we found that the provider had addressed this issue.

The registered manager confirmed that everyone currently living at Sunridge Court had capacity and therefore no people were subject to a DoLS. Although people had capacity, the home worked with a lot of people that were quite elderly and wanted their relatives involved in their care. We saw that people had signed their care plans. Where people's relatives were involved because they wanted them to be rather than because they lacked capacity this was documented in people's care plans. We asked the registered manager if MCA was reviewed, the registered manager told us, "If we notice any changes with a person that may indicate there may be an issue with capacity we will review."

We saw Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form in place for two people. These had been signed by the people, their relatives and a healthcare professional. We also saw one form where the person and healthcare professionals had documented that they required to be resuscitated should the need arise.

Staff had received training around DoLS and the MCA and records showed that this was refreshed on an annual basis. Staff understood the principles of the MCA and how this impacted on working with people. One staff member said, "Some people can't make decisions themselves. Where people can make decisions we must give them choice. Some people with dementia or mental health may not be able to make a decision and they would need a best interests meeting and someone who can make a decision on their behalf."

The home catered for the Jewish community and all food provided complied with cultural requirements. The executive director told us that all food provided was kosher. The catering was outsourced to an external catering company but the home had oversight of the food provided. We looked at the kitchen which was clean and tidy. Fridges and freezers were clean, well-stocked and any opened food labelled with when it had been opened and needed to be discarded. The home had recently received a five star rating form the environmental health department. There was guidance on the kitchen wall for the chef and staff around any allergies people had and guidance on diabetic diets. There were no people living in the home at the time of the inspection that had a specialist diet.

We asked people if they had choice when it came to meal times and snacks. People told us, "Everyone has different standards. They are willing to help you. They discovered ice cream for diabetics", "I am fussy but we have a lot of meetings. If you want a snack you can help yourself" and "I have never asked for snack or a drink but most days there is someone in the kitchen." There were four meal choices for each meal including, fish, meat and a vegetarian option. A menu was clearly displayed in the dining room for people to read. We saw that tea and coffee facilities were available in the dining room throughout the day. Snacks such as fresh pastries, fruit and crisps were also readily available and well stocked.

During the inspection we observed a lunch and dinner sitting. Tables were laid nicely with cutlery, napkins and fresh flowers. We saw that people were greeted warmly by staff and asked what their preference of food

was before being served. The registered manager was also present, greeting people and circulating the dining room to speak to people. People were served in a timely manner and food looked and smelled appetising.

Comments from relatives regarding the food included, "I think so [relative likes the food]. She's never complained", "It's on and off. That's the only thing she's not happy with. They're quite accommodating, it's just the cooking is not great, "Yeah he does, he really does like the food" and "She's happy with it. I think at the beginning a couple of years ago there were issues with the food, but it's all been put right."

Staff had regular handovers at the beginning of each shift and we saw that people's daily progress was documented in their daily notes. One staff member told us, "If anything changes, anything to do with residents, we are always updated at the beginning of every shift." A relative told us, "The communication between staff is good. At handover they leave each other notes."

People's personal files had details of healthcare visits, appointments and reviews such as dentists, doctors and opticians. Guidance given by professionals was included in people's care plans and updated if necessary. For example, we saw where a person had been discharged from hospital and their care plan had been updated to include physiotherapy appointments and how staff should support them. A healthcare professional told us, "They liaise very well with me. I give instructions if need be and I write it in the care plan when I have been. If I didn't document they [staff] would be running after me." People were able to access healthcare with support from staff where required and some people were supported to access private healthcare providers of their choice. Staff said that they knew about people's individual healthcare and how to refer people to the appropriate healthcare professionals.

Good

Is the service caring?

Our findings

We asked people if they thought that staff were kind and caring. People were positive about the staff and told us that they felt cared for. Comments from people included, "Everyone is very helpful and nice", "There are some lovely staff" and "They never got it wrong, I feel cared for and looked after." A relative said, "We hadn't needed the staff but when we did they have been unbelievable." A healthcare professional told us, "I would recommend it [the home]. I think the care staff are pretty good and pretty caring."

We asked relatives if they felt staff treated their relative with dignity and respect. Feedback included, "Yes. That's what I perceive when I see them. It's just clear to me", "[Relative] is in the position where she is able to complain if she needs to. All the carers seem to be quite fond of her. She's comfortable in where she is. I would say she loves it here, she says that we made a good choice moving her there", "Definitely. They always been very nice to her, they always have a chat with her and ask if she wants a cup of tea or coffee" and "Oh yes. It's a banter relationship as well. She can do her bit back as well."

Staff understood the importance of maintaining people's dignity. We asked staff how they ensured that they maintained people's dignity and treated them with respect. Staff comments included, "First and foremost, when you go into the room, you tell them good morning. If the individual needs personal care you make sure the door is closed and the curtains are closed. You deal with people how you would want to be treated. I offer them a cup of tea and ensure they are ready before personal care starts" and "You need to spend time with people before doing things. Kindness and compassion costs nothing."

We observed staff knocking on people's bedroom doors and waiting for a response before going in. People told us and we saw that they had keys to their bedrooms. One person said, "It's my home. They [staff] never go in without my say so." A relative commented, "They're always very polite to her. They're very caring. Even the cleaners don't just walk in; they always knock on the door. They treat her very well."

We observed several people coming into the office with questions and requests throughout the two days of the inspection. All people were greeted warmly and staff answered their questions in an appropriate way. We saw that one person came in to talk about their finances. The executive director told us that the person had always been used to having a 'rent book' in the past that documented their monthly payments and that their payments were electronically transferred at the home. To help the person feel confident and assured, the home had created a rent book that the person would take to the office and staff would sign each month.

The executive director told us that people were involved in the religious aspects of the home. Friday Shabbat dinners were held each week with people taking it in turns to say prayers. On Saturday mornings there were services held by volunteers from the local community, which people could chose to attend. A person told us that when they could not continue to attend his synagogue because it was too far they had services in the activity room that they volunteered at and said, "I am happy to do it." The executive director told us, "The Rabbi comes in on major Jewish holidays." We saw that all religious events were displayed on the communal noticeboard. A relative told us, "Staff have a respect for the religious culture."

Several of the people living at the home were celebrating their 100 plus birthdays in the coming weeks. The home had made plans to ensure that birthdays were celebrated with events that meant something to the person and involved family and friends. For one person, they were getting in a large choir as the person had been very involved with music. One person told us, "Staff make parties fun and make an effort."

We asked relatives, if appropriate and their relative wanted them to be, had they been involved in the care plan process? Relatives said, "Yeah actually saw it [the care plan] on Sunday", "Yes. I didn't ask for it, they asked me to come and read it" and "Not recently, but I have discussed it with them. I have addressed it recently with her medication."

Good

Is the service responsive?

Our findings

Care plans were detailed and person centred and people told us that they were involved in creating their care plans. Care plans contained practical information as well as information on people's personal preferences. There were comprehensive records of people's backgrounds, medical and personal histories which staff were aware of when we talked to them.

Where people were self-caring, their care plans were clear on what staff should be aware of. For example, one person's care plan stated, '[Person] is self-caring. Does not require assistance with personal care or dressing. [Person] may need help and support if they are unwell or their gout flares up'.

People living at Sunridge Court were generally very active. People told us that they attended activities in the community and one person said she continued to drive, "As long as my doctor lets me." We observed that people were able come and go from the home as they wished. One person said, "I like to go for a walk not to a particular place. I always tell them at the front desk." People that we spoke with talked about the "lovely large garden" and that they always had access to it. There was a visiting hairdresser that people were able to make an appointment with and the home had a small hairdressing salon. People were waiting for hairdresser appointments and one person commented afterwards they found it, "So refreshing."

We saw that there was an activities timetable and any planned activities were displayed on the home's notice board in the hallway. The home had an activities coordinator that helped plan activities and people told us that they had input into what activities they wished to do. There was a mixture of indoor and outdoor activities. Recent activities included a visiting lecturer from the RAF museum and an art history lecture. The executive director also told us about a scheme that people participated in where garden pots in the local community were maintained and planted by some of the people living at the home. There were also chair based exercise sessions twice a week, bingo, art and craft classes, poetry reading and a current affairs group.

We were told about an activity that people had decided they wanted to complete and had been set up with the activities coordinator in conjunction with the local authority. This was a local initiative to make 'fidget blankets' for people in other care homes that were living with dementia and/or sensory problems. The fidget blankets were large pieces of felt with objects such a different buttons or types of fabric that could be used to help stimulate people. The executive director told us that, "the service users won an award and the activities coordinator took one of the residents to meet the mayor and get their certificate."

We observed a film afternoon on the second day of the inspection. This used a projector to ensure a large screen in case people had difficulty with their vision. The film also had subtitles for people that may have had difficulty with their hearing. The executive director told us, "They [people] give us suggestions, we buy DVD's and we also have a Netflix account." A relative said, "Yes she is [encouraged with activities] but by choice she picks and chooses what she wants to do and she's happier spending time in her room reading. There's never any force."

Following an event held by the home on bonfire night, one person had written to the home and said, 'Just to

say thanks so much for such a lovely, 'bang up' firework evening. It was enjoyed by everyone. Just great.' Another person had written following the homes 50th anniversary party, 'To all the staff and management at Sunridge who made the 50th anniversary such a wonderful day.'

The home used volunteers to help ensure that people had over and above the care that was provided by the home. The executive director told us that volunteers often had a role as 'befrienders', spending extra time with people that may have been less able to go out regularly. The executive director told us that people who may benefit from this were identified and it was then discussed with them. The home also had a volunteer that came in once a week with a 'pat dog'. A pat dog is a form of animal therapy and the volunteer and animal had been trained by a local animal rescue centre.

The home ensured that people were able to communicate using technology. There were two communal computers that people had access to. The executive director told us that training had been provided to people by an external company in 'helping the elderly stay connected.' Each person had their own log in details and was supported by staff if required. For one person we saw that their care plan said that they used skype to contact relatives abroad each week and were supported by staff to do so. The registered manager told us, "Every week, without fail [person] calls their relative. We help but it's so important."

People were encouraged to stay in contact with friends and family and this was documented in people's care plans. A relative said, "They invite family members to a number of events. They go to a lot of trouble to write to wider families. They encourage involvement of family." People told us that their relatives were able to visit whenever they wanted to. Relatives told us, "We always go and try to see her once a week, she's had no restrictions, she has good support of her friends. She mixes well with the rest of her residents. She likes her visitors. She had her 90th birthday in January and they were quite cooperative in helping us throw her a party and all the residents were happy about it" and "She gets a visit from me and a visit from my brother. Between us we go every week or 10 days. It's not a problem."

There were regular reviews of people's care needs. The executive director was aware that if care needs became higher than the home was able to meet then referrals to higher care services were made. The executive director said, "We only have mild dementia here. As their dementia progresses we need to find a higher support placement."

People were involved in decisions about the home. There were regular recorded residents meetings and people told us that they were able to raise anything that they wanted to. The executive director gave us an example of the downstairs toilets. As there were more female residents than male, there had been a consultation to make the toilets unisex. This had been discussed at a residents meeting and people had voted to make the facilities unisex.

The home had a complaints procedure that was available for staff and people to read. People and relatives said that they had been given information by the home on how to complain but that they would talk to the registered manager or executive director if they needed to. People that we spoke with were positive about the complaint's procedure and some comments we received included, "There is a committee if you have cause for complaint you go to that committee" and "There is always room for improvement. Staff will always listen to any complaints." A relative said that if they had any concern or reason for complaint they would email and it would be responded to immediately. We observed that a person asked the executive director if they could speak to her about something and she immediately made herself available.

The home had received 17 complaints since the last inspection, the majority of which were around food. Where a complaint had been made, we saw that this had been investigated, an outcome noted and

feedback provided to the complainant in line with the providers complaints policy. The executive director told us, "We take complaints seriously and even minor issues we log as complaints and look into."

The home had also received written compliments which included, 'Your support has been exceptional and made our lives less difficult' and 'Thank you so much for all you have done for mum and our family.'

There were appropriate arrangements in place for end of life care and staff had received training in working with people at the end of their lives. There was detailed guidance for staff on dealing with individuals at the end of their life with dignity and respect and ensuring the person's wishes were carried out. There was also a section called 'anything you would not like to happen?' For example, this included things like, not being able to contact family members or not having an appropriate religious funeral. Where relatives had been involved in planning the care, this had been documented. A staff member told us, "We have had training in end of life care. I've sat with a resident when they are about to pass and been there when they take their last breath. It's part of caring for them."

One person's relative wrote to thank the home for ensuring that they were able to hold the Shiva at the home following their relative's passing. Shiva is an element of Jewish mourning following a person's passing and is usually held in the person's home. The relative commented, 'Thank you for letting me have the Shiva at Sunridge. I would like to thank you and all the staff at Sunridge Court for their kindness and care and support. It has meant a lot to mummy and me to have been looked after with such care and kindnesses.'

Good

Is the service well-led?

Our findings

There was a positive open culture within the service. The manager knew people using the service well and both people and staff were encouraged to voice their views and opinions. Staff were positive about working at the home and aware of the management structure. Staff told us, "[The registered manager] is really good and really caring about us and the residents. Always telling us about updates", "I feel supported. It's not like you don't know the chain of command. They're [the executive director and registered manager] always visible and their number is always available if you need to speak to them at night" and "The home is really well run. Residents are always the most important thing."

People told us that they knew the names of staff and referred to the executive director and registered manager by name. We observed people greeting the executive director and registered manager throughout the inspection and people clearly knew who they were. Relatives commented, "I think it's well run. The management seems very good and pleasant and you can talk to them" and "It's very personal, they're very caring. Overall it's a very well run home." Another relative told us that the management had, "Grown in structure" and improved and, "They seem to know people's little ways better."

Management had a consistent clear vision and strong values which was reflected when talking to staff and healthcare professionals. Staff were aware of the values of the home and had been trained in this during induction.

We saw regular audits of various aspects of the service. This included infection control, environmental audits, care plan and risk assessment audits and medicines audits. Staff files were audited on a six monthly basis. Where issues were identified, we saw that there were plans in place to address any issues found.

There were records of regular staff meetings that allowed staff to discuss care needs and development of the service. Staff told us that they could talk to the registered manager at any time.

The executive director and registered manager produced a monthly newsletter that was distributed to people and relatives. This was pictorial and contained information about the home, upcoming events, planned activities and information from residents meetings. We also saw that each month the newsletter produced a report on call bell analysis including how many times the call bells were rung, response times and actions to improve waiting time if necessary. Both the executive director and registered manager were passionate about communication and said they felt good communication had a positive impact on the people, relatives and healthcare professionals that they worked with.

The home completed annual surveys with people that used the service, their relatives and healthcare professionals. The most recent survey was available for people and relatives to read. Questionnaires were sent out and results collated into a short report. The survey was positive and noted any leaning for the home.

There were processes in place for the provider and registered manager to improve and share learning. The

executive director told us that she had a professional mentor who was involved in social care within the Jewish community and also attended bi-annual meetings run by the national Association of Jewish Care Homes. This was where all Jewish care homes in the country met to discuss aspects of health and social care, legislation and share ideas and plans for best practice.

With regards to local learning, the executive director said, "The registered manager takes part in the integrated quality and care team which is specific to Barnet. It's a team of people who are committed to health and social care in Barnet, being compliant with the regulations. We also have at least monthly registered manager forums where all care homes are invited. That's how we share learning. We are committed to being a part of that and it's fantastic for the registered manager to get to meet other managers and get support and share best practice." The executive director also told us, "They [local authority quality and care team] also have a role in activities and also offer clinical care training to managers. For example, two of our assistant managers attended pressure sore and ulcer training. They then can pass that knowledge on to the care staff here."

The executive director and registered manager had also received feedback from staff regarding training they would like and following this two bespoke training sessions had been completed; management training and team building. We saw feedback forms from the training sessions that were positive and staff that had attended commented that they had found them useful. Comments included, 'Learning new things from my co-workers gave me a better understanding on how to team build.' The executive director and registered manager ensured that there was an emphasis on learning and that it was an integral part of all staff members' development to ensure good quality of care.

The registered manager and executive director told us that they valued their staff and at the homes' recent Jubilee party all staff had been given certificates of recognition and a small gift to show appreciation. Staff that we spoke with also said that they felt appreciated by the management of the home.