Jewish Care

Lady Sarah Cohen House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 4 and 9 January 2017 and was unannounced. We last inspected the home on 6 and 7 January 2016 when we found the provider was in breach of two regulations, in relation to staff supervision and monitoring of changes in care records. The provider sent us an action plan stating what improvements they were going to make. During this inspection we found that the provider had made adequate improvements in relation to providing regular supervision sessions to their staff team including conducting group supervision. However, the daily care records were not consistent in detailing information on people's general wellbeing and how they spent their time.

Lady Sarah Cohen House is a nursing home registered to provide accommodation, nursing and personal care and support for up to 120 older people. Lady Sarah Cohen House is operated and run by Jewish Care, a voluntary organisation. At the time of our inspection, 104 people were living in the home.

The home is purpose built with dining and lounge areas on each floor. The home has 120 bedrooms with ensuite facilities split across three floors. All the floors are accessible via lifts and there is an accessible garden. The home shares kitchen and laundry facilities with another care home from the same provider. The home is part of the Betty and Asher Loftus centre, a community hub with access to a synagogue, shop and a café.

There was a manager in post, they were undergoing registration process with the Care Quality Commission. A registered manager is a person who has registered with the CQC 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 using the service told us they felt safe at the service. Staff had a good understanding of the safeguarding procedure and their role in protecting people from harm and abuse. The service had systems to identify and manage risks. The service maintained detailed risk assessments which were regularly reviewed, but we found a number of gaps. There was an improvement in daily care records since our last inspection however we found inconsistencies in them. People were generally happy with the support they received from staff administering their medicines. We found errors in medicines administration records (MAR) charts. The service was clean and had effective measures in place to prevent cross contamination.

The manager and service manager told us that there were sufficient numbers of staff employed to ensure that people's individual needs were met. However people, their relatives and staff told us there were not enough staff available at all times to meet people's individual needs.

People were provided with choice of food at meal times. Not all staff used appropriate methods to support people in making choices of what they wanted to eat. The service worked closely with various health and care professionals to support people with their needs and wishes.

The service followed safe recruitment practices. Staff received induction and regular training, and records confirmed this. Staff told us they found supervision useful and received regular one-to-one and group supervisions. The service was reviewing their appraisal system.

The service operated within the legal framework of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People told us staff asked their consent before supporting them. The manager and staff demonstrated a good understanding of the procedures under MCA and DoLS.

People using the service and their relatives told us they found staff friendly and caring. People told us staff listened to them and their individual health and care needs were met. However, they said agency staff were not always helpful and did not know people's needs.

The care plans included people's life histories, individual needs and likes and dislikes. People and their relatives were involved in planning their care. The service offered people a range of activities. People and their relatives told us they were asked for their feedback and their complaints were acted upon.

There was evidence of regular monitoring checks of various aspects of the service. However, these systems were not effective in ensuring records relating to people who used the service were accurate and up to date.

We have made a recommendation about accessing specialist advice in creating dementia friendly environment and specialist dementia training for staff.

We found that the registered provider was not meeting legal requirements and there were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to sufficient numbers of staffing to meet people's care and treatment needs, effective systems for the safe administration of medicines, recordkeeping and audits of care delivery.

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. People using the service, their relatives and staff told us there were not enough staff at all times to meet people's individual care needs.

The service lacked effective systems for safe medicines administration. Risk assessments were not always appropriately completed.

People using the service told us they felt safe. Staff were able to identify abuse and knew the correct procedures to follow if they suspected poor care or abuse.

The service followed appropriate recruitment practices.

Is the service effective?

Requires Improvement

The service not always effective. The environment was not dementia friendly. People were also not always appropriately supported to make decisions regarding meals. Care records relating to people's health were not always accurate.

People were supported by staff who received regular supervision. All staff including agency staff received suitable induction and training to do their job effectively.

The service liaised with relevant agencies to request mental capacity assessments and complied with deprivation of liberty safeguards. Staff understood people's right to make choices about their care.

Service worked well with the GP and other health and care professionals in supporting people to maintain healthy lives.

Is the service caring?

Good

The service was caring. The service supported people to remain as independent as possible. People were supported in maintaining relationships with their family and friends.

People told us staff respected their privacy and treated them with dignity.

The service identified people's wishes and preferences, religious, spiritual and cultural needs.

People and their relatives were involved in planning and making decisions about their care.

People's end of life care wishes were discussed and documented.

Is the service responsive?

Good

The service was responsive. Care plans were detailed, reviewed and updated to reflect people's changing needs.

Activities were available for people, including trips outside of the home. Some people wanted more stimulating activities.

People and their relatives were encouraged to raise concerns and complaints. Their concerns and complaints were listened to and addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led. The recordkeeping of health and care delivery was not consistent. Staff told us communication across staff team required improvement.

People, their relatives and staff told us the manager was approachable and helpful. Staff told us they were supported by the manager.

The service had systems for assessing and monitoring the quality and safety of the service. However, these were not always effective.

Lady Sarah Cohen House

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 9 January 2017 and was unannounced. The inspection was carried out by an adult social care inspector, a specialist advisor who was a nurse and a specialist advisor who was a pharmacist, both with professional experience of working with older people and people with dementia, and three 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.

Prior to our inspection, we reviewed information we held about the service, including previous reports and notifications sent to us at the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We looked at the information sent to us by the provider in the Provider Information Return. 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 contacted local authority commissioners and integrated care quality team about their views of the quality of care delivered by the service. We reviewed Healthwatch Barnet's Enter and View report.

During the inspection we spoke with 14 people using the service, and 15 relatives. We spoke with the manager, service manager, training assessor, senior of the family and carers' team, physiotherapist, social worker, Rabbi, living well team manager, three care managers, nine nurses, eight care staff and two volunteers. We observed care and staff interaction with people in communal areas across the home, including medicines administration, breakfast on one floor, lunch times on three floors and four activity sessions. Some people could not inform us on their thoughts about the quality of the care at the home. This was because they could not always communicate with us verbally and we could not understand how they communicated due to their complex needs. Because of this we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We wanted to check that the way staff interacted with people had a positive effect on their physical

and emotional well-being.

We looked at care plans, daily records and risk assessments for 19 people, and medicines administration records for 40 people. We looked at 14 staff personnel files including their recruitment and training, supervision and appraisal. We also reviewed staff rotas, accidents / incidents records, staff, residents' and relatives' meeting notes, activities schedule, quality audits, health and safety and monitoring checks, and records relating to the management of the service.

We also reviewed the documents that were provided by the manager after the inspection. Some of these documents included service's policies and procedures, accident and incident record, activities' records for third floor, and medicine audits.

Requires Improvement

Is the service safe?

Our findings

People using the service told us that they felt safe. People's relatives told us their family members were safe at the service. One person said, "I feel safe because I know that people are keeping an eye for me" and another person commented that the security was good.

The service had three units; each unit had two nurses and a minimum of eight and maximum of 10 care staff. In addition to this each unit were managed by one care manager who was also a registered nurse. The care home manager was available during the day for support. The staff worked in two shifts and there was staff handover at each shift change. The manager told us last year they piloted a dependency assessment tool on one floor to determine staffing ratio, and that it was work in progress. They were hoping to use the dependency assessment tool across all the floors in the next few months. Meanwhile, they were using the pre-admission assessment form to ascertain staffing numbers to meet individual needs. We were told by the manager they were using agency staff to cover care staff and nursing vacancies. We were informed by the management when using the agency staff the service used regular agency staff to provide consistency and familiar with people and their specific needs.

People and their relatives told us the staffing levels were low, agency staff were not always aware of people's needs and there was lack of staff continuity. They told us the staff were not always available to take them to the activities or toilets, and they had to wait for quite some time to get some help. Their comments included, "There are just not enough staff", "Agency staff on the last weekend was terrible, everything was late they don't know much about the residents" and "There is not enough staff which doesn't help me much." One relative said they did not think there was enough staff to meet the needs of their family member. They were also concerned that the frequent change of staff by the agency was not good. Other relatives comments included, "There is a lot of temporary staff on the first floor, my concern is that temporary staff does not know people and their needs" "Over Christmas there were a lot of temporary staff, regular staff have to train temporary staff. Staff are rotated too much; they should be allocated for longer and then rotated" and "They are overworked and that shows, especially during holiday periods."

Most staff we spoke to told us there were not sufficient staffing numbers. A staff member said, "Here there is a need for more staff as people's needs are complex." Another staff member told us that staffing levels were good but during mealtimes there was a "shortage of staff" as 10 to 12 people using the service required assistance with feeding. One nurse said, "Some agency staff who have been coming here regularly have become lazy. They need a lot of instructions and supervision and takes up time." During inspection we observed lunch time and saw some people had to wait longer than the others for their lunch. We saw people getting agitated.

We concluded that the above was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A care manager commented that insufficient staffing was one of the main issues. The management had interviewed couple of nurses and care staff, waiting for their security checks to come through. The manager

and the service manager told us they had recruited new care staff and nurses, and they had gone through all the necessary recruitment checks and were waiting for them to start working.

Staff told us they had received training in safeguarding adults and were able to describe types of abuse, and the signs of possible abuse they would look out for, for example marks or bruises, change in people's behaviour patterns, missing personal belongings. They were aware of the service's safeguarding policy and explained they would report any concerns to the manager. Staff we spoke with were able to explain service's whistleblowing policy and felt comfortable to follow the procedure if required. The manager told us staff were encouraged to raise concerns and, staff confirmed they had access to local authority's safeguarding team and Care Quality Commission's contact details if they wished to raise any concerns. The service maintained effective operations to prevent abuse of people using the service.

The service followed appropriate recruitment procedures to ensure staff were suitable to work with people. Staff had undergone Disclosure and Barring Service (DBS) checks and reference checks before starting to work at the service. Staff personnel files included completed application forms, copies of DBS and reference checks, and copies of identity documents to confirm people's identity and right to work. They also included training records and professional qualifications certificates.

We saw accidents and incidents records, these included action points and learning outcomes. The manager was able to explain the learning outcomes and actions taken to minimise the risk of further incidents. For example, we saw a falls accident form for one person who had an unwitnessed fall whilst walking in the corridors, one of the learning outcomes was for staff to closely monitor this person when they were walking around the building. The manager told us they discussed incidents that had occurred with the care mangers and the nurses in the staff meetings. This was confirmed by care managers and nurses and staff meeting minutes reviewed.

However, at inspection, we were told by one relative of a recent incident where they found their family member in the morning around 10am with not enough clothing and a white sheet further down the bed but not covering the person. The person was cold and coughing. The relative reported the incident to the nurse but nothing was followed up. We found the repositioning charts for this person inconsistent for the particular night and were difficult to follow as the date and timings were not in a chronological order. We spoke to the manager about this and they told us they were not informed of this incident and that they would follow it up and get back to us. Staff did not report this as per the service's policy therefore did not follow protocol for reporting incidents. During and following the inspection, we were not provided with an update on the outcome of the investigation.

The service maintained detailed and individualised risk assessments that informed staff on the risks and how best to manage them. The risk assessments were reviewed as and when people's needs changed but as a minimum they were reviewed every year. The risk assessments were for areas such as falls, environment, moving and handling, medicines and pressure ulcers. There were detailed nutritional risk assessments, food and fluid charts, and malnutrition universal screen tool (MUST) to monitor people's nutrition and hydration intake to meet their individual needs. However, we found MUST scores were not always correctly recorded.

People told us medicines were given on time and they were provided with pain relieving medicines when required. Some people told us they were happy with the support they received with the medicines management. One person said, "I take whatever medication they give me, they [nurses] know what they are doing."

We observed nurses on each floor administering medicines. Most staff followed correct procedures in

administering medicines. However, during lunch time we observed an agency nurse administer crushed medicine to a person's soup, gave it to a person with dementia who was sitting at the dining table next to two other people, and leave the person as soon as they had given the soup. We saw the agency nurse sign the medicines administration record (MAR) charts before they could be assured the person had taken the medication. We found this to be an unsafe practice, as the agency nurse did not make sure that the person had taken their medicine before signing the MAR chart that the person had taken the medicine. The agency nurse also left the person with their medicine unattended whilst they were sitting next to two people who had easy access to the cup, leaving all three people at risk of harm.

We spoke to the manager about the above mentioned incident and they told us they had taken a statement from the agency nurse which was different to our observation. The manager told us they would further investigate the matter and inform us of the outcome. During and following the inspection, we were not provided with further information on the incident. The service lacked effective systems for the safe administration of medicines.

Medicines folders consisted of people's identifying photo, allergy information and list of medicines. Some people's identifying photos were missing that was because they were still being done. MAR charts were reviewed and we found errors in them which highlighted record keeping discrepancies. For example, one person was given medicine on time but was not signed for in MAR chart. We found the records were not always accurate. For example, we found night staff had signed in MAR and patch charts for applying patches, however, they had been applied by the day staff and there was no explanation on the reverse of MAR chart relating to the record keeping discrepancy.

People received medicines in blister packs that were supplied by the local pharmacy. The medicines were ordered via local pharmacy; they would collect them and liaise with the GP for repeat prescriptions. The pharmacy delivered medicines a few days before the existing stock ran out and collected any spare medicines. The care manager told us the nurses were responsible for ordering and checking medication in. The service's policy states "admission section states that all records should have two staff signatures to ensure all checks have been carried out and counter signed." However, at inspection, we saw MAR charts on two floors only had one staff member's signature recorded for booking in new stock deliveries.

We concluded that the above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nurses we spoke with demonstrated a good understanding of medicines policy and procedures. Nurses told us they received regular medication training and felt equipped to administer medicines. Internal and independent external medicine audits were carried out. We saw records of the internal and independent audits and there were areas identified that required addressing. At the inspection, we found some areas of concerns that were identified during internal audits. We spoke to a care manager who told us they did not have time to address the issues as they were very busy during the holiday period. Following the inspection, the manager sent us an action plan drafted based on internal and pharmacist independent audit with outcomes, target dates and achieved dates. The manager told us medicines errors were immediately reported to the care managers by the nurses and they investigated them. If an error was confirmed then the manager would seek help from the pharmacy and the doctor alongside reporting to all concerned professionals.

Controlled drugs were kept securely and we checked the stock against those recorded in control drug register and found them to be compliant. Medicines were stored safely and securely. Room and fridge temperatures were monitored. Where discrepancies were identified we saw documented evidence that the

service had acted on these.

Infection control practices were followed by the service. We saw staff using personal protective equipment including gloves and apron whilst supporting people with personal care. The service was well maintained, clean and no mal-odour was present. People and their relatives told us they were happy with the cleanliness.

We found oxygen cylinders were not secured to the walls or in oxygen holders as per the provider's policy and other emergency equipment such as suctioning machine were not regularly checked. Following the inspection, the manager told us they had checked and tested the equipment and devised a chart for regular monitoring of the equipment. We looked at fire drill records, water tests and maintenance and electric and fire equipment testing records. The service had records of hoist and wheelchair equipment testing records. They were all up-to-date.

Requires Improvement

Is the service effective?

Our findings

People using the service and their relatives told us regular staff understood their health and care needs and were able to provide the right support. One person said, "They seem to know what they are doing. I think they do an incredible job." A relative told us, "When my [relative] was not well, we were called in and the staff communicated to us at the right time." However, some people told us that agency staff did not always know their needs and what was expected of them. People's comments included, "95% of staff knows what they are doing. The night staff are not as efficient as day staff", "Some [staff] are better than others", "I think permanent staff are kinder than the agency staff", "Some staff talk to me whilst giving support, but not all do" and "If I complain, they [staff] just leave and go."

New staff were required to complete the Care Certificate standards that included training in areas such as safeguarding, health and safety, moving and handling, person-centred way, risk assessments and service's policies and procedures. During induction new staff would shadow established staff. At the completion of the induction programme new staff had to complete workbooks which were assessed by the provider's qualified assessor and if the standards were met they would be signed off. The manager would check that all standards were met and sign-off the staff member as competent to be able to perform their duties un-supervised. Staff induction completion records confirmed this. Staff we spoke with told us they found training useful and gave examples of the training they had completed such as infection control. We looked at training records and certificates in staff files. These confirmed the variety of training offered to the staff team. The manager told us staff received annual refresher training courses in areas such as safeguarding, health and safety and moving and handling.

We looked at the staff supervision and appraisal records and confirmed staff were receiving regular supervision. The care managers carried out regular group and quarterly one-to-one supervision sessions. However, there were gaps in appraisal records. The manager and service manager told us they were reviewing the appraisal process as the existing one was not effective. They said the new appraisal system would be piloted at the end of this month. Staff told us they were happy with the management and were very well supported by the manager.

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.

There were clear records in the care plans on people's ability and capacity to make decisions and how staff should support people to make decisions. People's care plans had clear information on who could make legal and financial decisions on people's behalf should they lack capacity to make a decision regarding their care. The service sought consent from people to deliver care and share their information, records seen confirmed this. Where people were unable to give consent and did not have lasting power of attorney, best interest decision meetings were conducted and decisions were made in people's best interest, records seen

confirmed this. Staff had received training on MCA and DoLS and staff we spoke with had a good understanding of MCA and DoLS, and how they obtained people's consent when offering to support them. Staff were able to explain how they would support people who lacked capacity denied some aspects of care such as medicines, personal care.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw DoLS authorisation from the local authority in place.

Most people and their relatives told us the food was good and they were given choices. People's comments included, "the food is delightful", "the food is very good, spaghetti bolognaise is the only dish I don't like but if I speak to the kitchen in advance I can get chicken nuggets instead" and "food is balanced and there is always fresh fruit."

The manager told us they consulted people regarding food via regular residents and relatives meeting. They also conducted food forums to find out about people's thoughts on food and to know about their likes and dislikes. We evidenced records of these meetings. The service operated a catering system for Jewish dietary law and a four week menu rotation with added detail of potential allergens. The food allergies and specific diet information was on display in the dining room for an easy access. People told us their specific needs around food and drinks were met, such as people on soft food diet, gluten free and diabetic diets. We saw people were given choice of cereals, toast, fruits and boiled egg for breakfast. We met with the new chef who told us they were consulting people and relatives to design new menus and introduce two weeks' menu. We saw a draft of two weeks' menu.

Breakfast, lunch and supper were served both in the dining areas and in people's bedrooms as per people's choice. We saw people were assisted by staff, relatives and volunteers during meal times. On the second day of inspection, people were seen waiting for breakfast as the kitchen was running behind due to staff arriving late because of tube strike. We noticed staff had given tea and coffee and biscuits to those people who wanted to have something to eat whilst waiting for breakfast. Throughout the inspection, we saw people being offered hot drinks, juices and biscuits. We saw people feeling comfortable in asking for drinks and biscuits.

We observed lunch on all three units. The food had arrived on time from the kitchen. Some people were already sitting in the dining areas waiting for their lunch to be served whilst staff were supporting other people to access dining areas. Lunch was well presented and the menu was displayed on the dining tables however not everyone was able to read the menu. People, who could read the menu, were offered choices. However, not all staff used personalised methods to offer choices to people who could not read the menu. Therefore people were not always appropriately supported to make a decision of what they wanted to eat.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to supporting the specialist needs of people living with dementia at meal times.

As a good practice, the service weighed people on a monthly basis. We saw weight management records; people's weights were mainly stable. Staff were able to describe the way they supported and encouraged people to maintain a healthy lifestyle and balanced diet. Staff were able to describe risks associated with diabetes such as hypoglycaemia and hyperglycaemia and signs to look out for low and high blood sugar levels. We looked at people's daily care records; some of them included information on people's nutrition and hydration intake. The service maintained appropriate night hourly checks and repositioning charts.

However, we found inconsistency in one person's repositioning chart. This person's repositioning chart indicated that no turning took place from 19:10 until the following day at 20:10. We spoke to the manager about this and they told us they would investigate it and get back to us. During and following the inspection, we were not provided with any further information on this discrepancy.

People and their relatives told us they had access to health and care professionals. We saw records of this in people's care records. The manager told us the GP visited every week. We saw GP's medicine review records. We saw wound / blister management plan and instructions from district nurse. The service worked well with other health and care professionals in supporting people to lead healthy lives.

The service was well maintained and purpose built with wide corridors to allow good wheelchair access. There were open plan spacious lounge and dining areas on all the three floors and an accessible garden. People's bedrooms had ensuite facilities. There were recreational and faith facilities, including a Synagogue, shop and café they shared with some of the provider's other services. On the first floor, on the side of people's bedroom doors there was an accompanying display box, some of these boxes had people's photos were displayed. The manager told us they were in process of introducing memory boxes on other two floors. However, there were no other personalised items on display in the memory boxes or memory boards that reflected people's backgrounds. There was a lack of signage and colour zoned walls to support people with dementia in accessing various rooms and facilities in the service. The management told us that the provider had identified the issue through their internal audit in December 2016 and had commissioned improvements. Report seen confirmed this.

Good

Is the service caring?

Our findings

People using the service told us they found staff caring and friendly. Their comments included, "They are very nice, no problem", "They give their help with joy, not grudgingly. The atmosphere is a joy", "The staff here are very good, I am well looked after" and "I appreciate their kindness and I am grateful that they are always polite." One relative told us, "My mother gets good care considering her condition." People and their relatives said there were no restrictions on visiting times and those visiting were made to feel very welcomed.

During our inspection, we saw positive interactions between staff and people using the service and between people themselves. Staff were patient, kind and sensitive with people and listened to their needs. We saw the service had various visitors including family members, friends, health and care professionals and volunteers. At inspection, we saw two staff using their mobile phones whilst sitting next to the people they were meant to be supporting. We were informed by some relatives that they had noticed agency staff using their mobile phones when they should be engaging with people thereby people not receiving care and support they needed. We spoke to the manager about staff using their personal mobile phones whilst working with people and they told us they would organise a staff meeting to remind them of the mobile phone usage practice.

One of the dining areas had an aquarium with a number of colourful fish donated by a family member, and we saw people looking delighted with it. Staff told us they celebrated people's birthdays and the cook baked sugar free birthday cakes for them. We saw birthday celebrations for a person who had just turned 98 years old. The person looked delighted with the cake and all the attention they received.

People and their relatives we spoke to told us staff treated them with dignity and respect and that they were listened to. One person said, "They (staff) always knock on my door and ask if they can come in. That's respect, I think." One relative told us, "The staff are very friendly, but they are also very courteous to everyone." Staff gave examples of how they ensured people's privacy was respected and dignity in care maintained when providing care to people. For example, staff told us they would not rush people when assisting with meals, always knocked on people's doors and waited to be invited in the room before entering, they closed bedroom and bathroom doors whilst assisting people with personal care. We saw staff not rushing people, for example, during meal time staff were encouraging and supportive to people who ate slowly.

The manager told us staff tried their best to encourage people and engage with them in planning and making decisions about their care. People's relatives told us they were involved in their relatives' care planning and reviews and were invited to care reviews.

Staff told us they empowered and encouraged people to stay as independent as they were able to. For example, we saw one person with wheelchair, access lift by themselves, they told us they were confident in using the wheelchair and often used it to go to the café on the ground floor or join in activities on other floors. One staff member told us, "[person] requires support with personal care although she prefers to

brush her own teeth, and I support her with that and encourage her."

The service recognised people's individual needs in regards to race, religion, sexual orientation and gender. The service supported people in weekly religious practices. Friday night Kiddush and Shabbat services were held each week and all Jewish festivals were celebrated. However, people who chose not to follow some aspects of religious rituals due to their health condition they were supported by staff to achieve their wish without affecting other people's religious beliefs. People benefitted from a Rabbi's visit twice a week. During our inspection, we observed the Rabbi positively interact people and people told us they looked forward to the Rabbi's visit. We spoke to a senior of the family and carers' team who told us they were working with people and their relatives in providing emotional support where necessary. They were also developing a team of volunteers who would engage with people and their relatives in providing emotional support.

We saw people's bedrooms with their personal belongings, providing a homely environment. Some people had photographs in their rooms and other memorabilia. Staff were able to explain the importance of confidentiality and respecting people's private information. We saw people's personal information was stored safely.

Staff had discussions with people where possible and their relatives around their wishes and preferences about their end of life care and these had been recorded in their care plans. Care plans provided personalised information regarding the support people wished to have during their end of life care including their funeral wishes. The manager told us people were supported to remain at the service in their last days. We saw some people's completed Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and advance care forms mention their wish to stay at the care home in their last days.

Good

Is the service responsive?

Our findings

People using the service told us staff understood their individual health and care needs and were responsive to their needs. The manager told us care managers assessed people's needs and completed pre-admission assessment form before they moved to the home and began receiving support. People and their relatives were invited to look at the bedrooms and other facilities offered in the service before confirming their move. The pre-admission assessment included information around health and medical needs, mobility, communication, mental health, nutrition and hydration needs. This information was used to draw up people's individual care plans. The care plans were drawn up during people's stay in response to their needs.

We saw people's care plans, they were reviewed every month or sooner when there was a significant change in people's health and care needs. This meant staff were provided with the most current information on people's health and care needs which enabled them to deliver efficient care. Staff were also informed on people's current health and care needs by the care managers at daily handover and weekly staff meetings.

The care plans were detailed and outlined people's needs, abilities and how their needs were to be met. For example, one person's care plan stated "[Name] able to use call bell but prefers to call for help than using the call bell, but still would like the staff to put the call bell beside her where she can reach." The care plans included people's personal information, family, life history, eating and drinking, cultural and religious needs and health related information and correspondences. The care plans also included people's hobbies and activities preference sheet which included an evaluation section to monitor how well people were engaging in activities. For example, one person's care plan identified desired outcome was "to provide stimulation and prevent boredom" and one of the action points was "to encourage [Name] to come out of her room and join other people and activities in the lounge." One person told us how after moving to the service they would take meals in their room but staff encouraged them to join others in the dining area. They now take their meals with others in the dining area and enjoy interacting with others too.

Although, care plans and daily care records were personalised they were not consistent. The manager and service manager told us they were introducing electronic care plans which would be user friendly. This would enable staff to document details around care delivery and save time in writing up daily care records. They told us staff that did not have English as their first language were given training on how to write daily care records. Records seen confirmed this.

People and their relatives told us they were included in their care review meetings, and were able to express their views and wishes regarding their care. One relative commented, "I was recently invited to attend a care plan review meeting for my family member and was involved in best interest meeting."

People with various levels of abilities and needs were living at the home. This meant some people were independent enough to carry out their preferred choice of activities and there were others who needed assistance and support in engaging in activities. For example, we saw one person watching videos on a computer in their bedroom, another person doing crossword puzzles and reading newspaper. One person

told us they had recently moved to the service and had been on a couple of outings which they had enjoyed. One person said they attended group activities three times a week and we also saw them co-facilitate a discussion group organised by the service. The service's living well engaged with people to identify their interests and hobbies. Activities offered included mobility, reminiscence, discussions, quiz, music and exercise. Over two days of inspection, we observed six group activities delivered by volunteers and living well team members; these were movement session using balloons, reminiscence group, a discussion group, talk on fashion in the 1930s, quiz and movement therapy. We saw people enjoying the activities and the activities were facilitated to include those who were less able to participate. We saw staff supporting people to access these activities.

However, people on one floor told us there could be more activities. Their comments included, "I don't find there is enough to occupy myself; activities are not suitable for my specific needs. I want something more intellectually stimulating. I watch television a lot." Another person said, "There are not enough activities. I brought my own board games. I don't get to go out." One relative told us, "Stimulus is vital for those with dementia, and that is just not happening here." Although people felt like that the provider did have a range of activities. We spoke to the manager regarding people's response around lack of stimulating activities. Following the inspection, they sent us a list of activities that were carried out and various ways living well team engaged with people on the day of inspection on that particular floor. The manager told us they would ask living well team to work with people on that floor to update the existing activities schedule.

We saw televisions were left on but people were not seen watching them. There were times when music was playing off the music player, but the televisions were still left on with volume turned off. We saw not all staff were interacting whilst supporting people. We spoke to the manager about staff not interacting with people and not engaging with them whilst supporting them. The manager said they would organise a staff meeting to remind staff of their roles and responsibilities. They further said actions would be taken against staff that were seen not engaging with people whilst assisting them in their care.

People told us they liked their rooms and it was their space. The service was undergoing refurbishment work and people were involved and consulted in this process.

People told us they attended residents' meetings and found them useful. The manager told us at the residents' meetings they encouraged people to say how they felt about the service, if they had any concerns or specific wishes. We saw notes of residents' meeting, demonstrated people's views, comments and concerns. People's relatives told us they were invited to relatives' meetings where the manager asked them about their views and opinions about the service. Relatives told us they did not have to wait for such meetings to voice their views, they could visit the manager anytime and they would be listened to.

The manager maintained an open door policy and people were actively encouraged to raise their concerns or complaints. People told us if they wanted to make a complaint they would speak to the manager and that they felt comfortable to do so if required. People and their relatives felt comfortable raising concerns and complaints. They told us their complaints were listened to and acted on.

The provider's complaints procedure was easily accessible and the policy detailed guidance on how to complain and specific timescales within which people should expect to receive a response. There were clear processes in place to effectively respond to complaints. We saw records of complaints and responses and they were compliant with the service's policy.

Requires Improvement

Is the service well-led?

Our findings

The service had been without a registered manager for several months. The service's current manager was going through the registration process with the Care Quality Commission.

The service carried out regular audits to ensure the quality of the service. We saw records of regular audits; the manager visited the service unannounced at times at late nights or early hours in the morning to monitor the quality of the service. Records seen confirmed this. There were records of health and safety checks. The manager told us they regularly checked people's bedrooms for cleanliness and hazards to ensure they were maintained at expected standards. The manager undertook regular walks around the service, identifying areas for improvement. The manager attended monthly provider's management meetings where health and safety issues were discussed and action plans created. We saw meetings notes. The manager also conducted quality assurance meetings where they encouraged staff and residents' to voice their issues. The quality assurance meetings were chaired by a volunteer and notes of these meetings confirmed this.

However, the audits were not always effective in ensuring records relating to people using the service were accurate and up to date. We found errors in people's MAR, patch and repositioning charts. The daily care delivery records had considerably improved since the last inspection, however there were still some inconsistencies. For example, not all staff were recording information on what people had done during the day and some records were just a repetition of the previous day. One relative said, "Care staff spend long time to write their daily notes but nothing is been mentioned about significant issues that happened like incidents; they are only used to writing that the residents are fine and pads are changed." We found gaps in some risk assessments. For example, inconsistencies in two people's nutritional risk assessments, malnutrition universal screen tool (MUST) and food and fluid charts did not corroborate the identified risk and action points. There were Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms for people; however we found not all were appropriately completed. There were records of audits and spot checks to monitor the quality of the service. The service's audit process had not picked up the inconsistent recording of care delivery, gaps in risk assessments and errors in MAR charts, but this had subsequently been included. The service overall lacked accurate, complete and contemporaneous records including records of the care and treatment provided and ineffective audits.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, their relatives and staff were asked for formal feedback annually via questionnaires and informal feedback on an ongoing basis. We saw 'your care rating' residents' and staff survey results for the year 2015, and relatives' survey results for the year 2016. The manager told us residents' and staff survey results for the year 2016 should be arriving soon and they will forward it to us as soon as the data has been analysed. The analysis for residents' survey results of 2015 showed 78% people were overall happy living at the service and 87% of people were satisfied overall with the service. Following the 2015 survey results, the manager recruited a new chef to improve on the variety of food offered to people. The manager organised a food

forum to consult people on food options.

The manager worked with various health and social care professionals in delivering efficient care services to people. In addition to working with Jewish Care services, they worked with hospitals, GPs, district nurses, palliative care team, North London Hospice, social work team, Huntington's, Parkinson's and Multiple Sclerosis society. The service is working on research projects with The Foundation of Nursing Studies and South East England to develop a training ethos within the home, the UCL about caring for people with dementia who exhibit challenging behaviour, ECL Outcomes star and with Jewish Deaf Association to train staff around hearing loss. The service was also working with Skills for Care in piloting an appraisal system for care staff in care homes. The manager worked closely with the provider's departments and attended provider's registered managers' forum for continuous improvement.

People using the service, their relatives and staff told us the manager was approachable and helpful. The service is a large care home with three units and each unit has an allocated care manager. People and their relatives told us they mainly spoke to the care managers and if they were not happy with the care manager's response they approached the manager. People's comments on the manager and the management of the service included, "She [the manager] is a nice person" and "I think the home is run satisfactorily and would be happy to raise concerns." One relative said, "I think the standard of care here is very good. I can recommend this nursing home to other people." Another relative told us, "The current manager keeps me informed on any concerns related to my mother's health."

We received mixed feedback from health and care professionals. One professional said the manager was supportive and cooperative. But another professional said they had never met the manager and it seemed like no one knew what was going on. The manager told us they were trying their best to be seen around the service. They did regular rounds on all the three floors especially during meal times. One person using the service said they knew who the manager was as they had seen them walking round the floors. They also had lunch in the café area in the service to be accessible to the visitors and professionals. We observed the manager doing rounds on the units and interacting politely and patiently with people, their relatives and staff. We observed positive and supportive interaction between members of staff and that they worked well as a team on each unit. We saw staff encouraging each other to take breaks.

Staff told us they found the manager helpful and approachable. One staff member said, "The manager is lovely. She is responsive, listens to me always." Staff we spoke to told us the management had improved but felt "the communication between the staff team needed improving" and there was "a need to work as one home rather than individual units." The manager and the service manager told us each unit in the past was registered as an independent nursing home and hence, people and staff on units were accustomed to functioning independently. However, staff were encouraging people to access other units for group activities. Similarly, the manager was also encouraging staff to work on different units to promote teamwork.

The service had recently introduced weekly reflective practice, where the care managers discussed topics chosen by the staff team along with updates on people's needs. At the monthly staff meetings the manager discussed various accidents and incidents, safeguarding cases and other areas of care delivery. We saw records of these meetings. Staff told us the manager involved and consulted them on various matters affecting care delivery. For example, one care manager said that they had suggested simplifying daily care records and the management were considering electronic care plans and daily care records.

Most people and their relatives told us they knew about residents' and relatives' meetings and found them useful. The manager told us they encouraged people and their relatives to express their concerns and

wishes at the residents' and relatives' meetings. Residents' and relatives' meeting notes confirmed this. The manager told us they asked people their views on staff and the care delivery including food, activities and outings. People's views were then discussed with staff in the staff meetings. We saw evidence of this in staff's meetings notes.

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 Care of people was not provided in a consistently safe way. This included failure to ensuring the proper and safe management of medicines. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to effectively operate systems to: assess, monitor and improve the quality and safety of the services provided; accurately and completely maintain records in respect of each service user. Regulation 17(1)(2)(a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not deployed to meet people's needs effectively. Regulation 18(1)