Jewish Care

Jewish Care North London and Hertfordshire Home Care Service

Inspection report

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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 10 and 11 August 2016. The inspection was announced and the provider was given 48 hours' notice that the inspection was going to take place to ensure that the registered manager would be available throughout the inspection process.

The service was last inspected in January 2014 and was found to be meeting all the outcomes that were looked at during that time.

Jewish Care North London and Hertfordshire Homecare Service provide domiciliary care services to approximately 44 older people living in their own home. The service only provides personal care and support to members of the Jewish community. People are supported with a variety of health needs including supporting those living with dementia, physical disabilities and other high care needs.

A registered manager was in post at the time of the inspection. 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.

Feedback received from people and relatives was positive and people were happy with the care and support that they received from the agency.

Each person had a detailed care plan which included information about the person and the care and support that they required. A pre-service assessment had been completed along with an environmental and generic risk assessment which identified some common risks associated with people's care and support needs. However, although the service identified individualised risks associated with people's care, these risks were not assessed and relevant information was not available in order to mitigate those identified risks in order to keep people safe from harm.

Care plans were detailed and person centred. People's likes and dislikes as well as choices and preferences had been recorded. A background history of the person had also been recorded which gave insight about the person and their life history.

The registered manager, assistant managers and care staff had a good understanding of the principles of the Mental Capacity Act 2005 (MCA). Training records confirmed that each staff had received training on the MCA. In addition, each care plan that we looked at had been signed by either the person receiving care or where the person was unable to sign, a relative had signed on their behalf consenting to the care and support that they were receiving.

People and relatives that we spoke with were happy with the care that they received and felt safe with the care staff that supported them. Care staff had a good awareness of what safeguarding was and the actions

they would take if abuse was suspected.

The service followed safe recruitment processes to ensure that only suitable staff were employed to work with people requiring care and support. As part of the recruitment process staff underwent an in-depth induction period which covered a variety of topics including mandatory training in subjects such as manual handling, first aid and safeguarding.

Care staff told us that they felt supported in their role and received regular supervision. Records that we looked at confirmed that since the current registered manager had been in place systems were in place ensuring that care staff received regular supervision. However, previous to the current registered manager it was noted that regular supervisions were not taking place.

People were supported with their medicines by care staff. Systems and processes were in place to ensure safe management of medicines. However, where care staff were required to administer medicines we found that care staff did not complete a Medicine Administration Record (MAR) confirming which medicines and at what times these medicines had been administered. An in-house daily recording sheet was completed but this did not give information about the medicines being administered.

A complaints policy was in place as well as a complaints folder which held records of all complaints that had been received and the actions that had been taken to resolve the complaint.

People and relatives told us that staff were caring and had become part of their family. They felt they were treated with dignity and respect and their wishes and choices were always taken into account.

A number of quality assurance systems were in place which monitored the overall running of the service. We saw that the registered manager had put in place systems to monitor missed and late visits as well as conducting weekly telephone monitoring calls to obtain feedback from people and relatives using the service.

People, relatives and care staff were sent annual survey questionnaires requesting feedback on the quality of the service that they received. Staff surveys focused on how they felt working for Jewish Care and, if anything, what would they change about working for Jewish Care. The last quality survey was completed in 2015.

We identified one breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to assessing people's personal risks associated with their care and support needs. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Although the service identified individualised risks associated with people's care, these risks were not assessed and relevant information was not available in order to mitigate those identified risks in order to keep people safe from harm.

The service had safe recruitment processes in place to ensure that only suitable staff were employed.

People and relatives told us that they felt safe with the care staff that supported them. Care staff had a good understanding of what constituted abuse and the actions they would take if abuse was suspected.

The service had systems and processes in place for the management of medicines.

Is the service effective?

Good

The service was effective. Care staff knew about the Mental Capacity Act 2005 (MCA) and how this impacted on the way they supported people with their needs and requirements.

Consent to care was obtained as part of the care planning process.

Care staff received training which covered a variety of topics. All care staff were required to attend an eight day induction course and we saw evidence that training in the mandatory subjects was refreshed on an annual basis.

People were supported with their health needs as and when required. Care staff were able to describe the actions they would take if a person required urgent support with their health.

Is the service caring?

Good

The service was caring. People and relatives told us that they were happy with the care and support that they received. People were complimentary about individual care staff and told us that

they were treated with dignity and respect.

People and relatives told us that they received care from a regular team of care staff who had become part of their family and had built positive working relationships with them.

People told us that care staff always listened to them and always respected their choices and wishes.

Is the service responsive?

Good

The service was responsive. A complaints policy was available and people that we spoke with knew that if they had any complaints or issues to raise, they felt able to contact the office and speak to one of the senior managers.

Complaints that had been received were recorded with an audit trail of the actions taken and the outcome of the complaint.

Care plans had been reviewed regularly and people and relatives we spoke with also confirmed this and told us that they had been involved with the review process.

Is the service well-led?

Good

The service was well-led. The registered manager had put in place a number of systems and processes to monitor the overall management of the services which included spot checks and audits of care plans and staff files.

We saw the results of the most recent quality assurance survey held in 2015, which had been sent to people and relatives in order to obtain their views and experiences on the quality of service that they received. A management review had been compiled as a result with a plan of action for improvements that were required.

Care staff completed a staff survey which focused on obtaining views on their experience of working for the provider as well as any suggestions they may have for further improvements.

People and relatives knew who the registered manager and the assistant managers within the office were and felt confident and able to contact them if they had any issues or concerns.

Jewish Care North London and Hertfordshire Home Care Service

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 the 10 and 11 August 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care and we needed to be sure that the registered manager would be available to support us with the inspection process.

During the two day inspection process we visited three people, with prior consent, in their own home to speak with the about the care and support that they received from the agency. As part of the visit we looked at the agency records that were kept at the person's home. In addition to this, two experts by experience spoke with nine people and six relatives over the telephone. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was carried out by two inspectors. Before the inspection we looked at the information we had about the service. We reviewed the completed Provider Information Return (PIR). The PIR is a form that askes the provider to give some key information about the service, what the service does well and any improvements that they plan to make. We also reviewed other information we had about the provider, including notifications of any safeguarding incidents or any other incidents affecting the safety and well-being of people.

During the inspection we spoke with the registered manager, two assistant managers, four care staff as well

as the Assistant Director of community services within Jewish Care. We looked at eight people's care plans, six care staff files which also included staff supervisions and appraisal records as well as other documentation which included training records, a variety of policies and procedures, staff meeting minutes and quality survey results.

Requires Improvement

Is the service safe?

Our findings

People and relatives that we spoke with told us that they felt safe with the care staff that supported them. One person when asked if they felt safe told us, "Oh yeah, I have known them for some time." Another person commented, "I feel very safe with the carers they know what they are doing." Relatives, when asked about the safety of the person being cared for told us, "Yes. There are no risks at all. We have regular staff and they talk to him" and "Yes. Absolutely 100 per cent." Despite these positive comments we found that a particular aspect of the service was not safe.

Each person receiving a service had a care plan in place which provided information about the person and their required care and support needs. As part of the care planning process the service completed an environmental risk assessment and a personal risk assessment which identified potential risks within the person's own home where care and support would be provided. Information on the risk assessment provided guidance and direction to staff on how to mitigate risk in order to keep people safe and free from harm. In addition, as part of the personal risk assessment, the service did identify individual risks associated with people's care and support needs, however, the service did not assess people's individual identified risks and did not give detailed information and guidance to care staff in order to reduce the risk of harm that may occur.

For example, for one person, the service had identified that they were at high risk of falls, however sufficient information or guidance had not been provided to care staff in order for them to safely manage the risk to ensure the person's safety. Another example seen included care staff supporting a person with high risk diabetic medicines. Although care staff were not supporting with administration of the high risk medicine, there was no guidance available for care staff on what to do if the person suffered a drop or rise in blood sugar levels. A third example noted was about a person suffering with Chronic Obstructive Pulmonary Disease (COPD) which is an illness of the lungs. This condition had not been noted on their risk assessment and there was no information available for staff on how this condition may affect the person.
Some care plans that we looked at included a medication profile as well as a medication risk assessment which outlined the details and level of support the person required with the management of their medicines. However, the medicine risk assessment failed to note any risks associated with the medicines.

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

We spoke with the registered manager, the assistant director of community services and the service manager about the issues we had found around risk assessments who agreed that this was an area that had not been appropriately addressed. The next day following the inspection we received updated risk assessments for people whose care plans that we had looked at incorporating changes and updates that were required. The registered manager also assured us that all care plans and risk assessments would be updated to ensure that they provided information and guidance on how to mitigate risks and keep people safe from harm.

Accidents and incidents were recorded on an accident and incident form. All accidents and incidents were reported to the office and a record was made which outlined the date of the incident, details of the incident and what action was taken. These forms were checked by the registered manager after every incident and a copy of the record was also kept in people's care plans. The registered manager collated information about accidents and incidents on a weekly basis in order to monitor any emerging trends or patterns.

A medicines policy was in place and available for care staff to follow if guidance was required when supporting people safely with their medicines. Care plans that we looked at contained detailed information about how a person was to be supported with their medicine. For example, where a person was self-medicating, this was clearly recorded on the medication risk assessment within the care plan. Where a person required prompting, this was clearly documented and daily care records corresponded with the care plan and the support that was provided by the care staff.

However, where care staff were required to administer medicines as part of a person's support plan, care staff were only recording their actions on a medication record sheet which did not detail the name of the medicines, the dosage and direction on how the medicine should be administered. The records sheet only allowed the care staff to record the date, time of visit, any comments and the care staff signature confirming whether the medicine had been administered. A Medicine Administration Record (MAR) was not available. As part of the daily medication record, a coding system was available for care staff to utilise if the person had refused their medicine or if the person was not available or where the medicine was not available.

We highlighted this discrepancy to the registered manager who acknowledged that this was an area to be looked at and confirmed that they would obtain correct guidance and ensure appropriate records were put in place to ensure the safe administration of medicines.

Training records that we looked at confirmed that all care staff had completed medicine training and this was refreshed on an annual basis. Care staff that we spoke with confirmed that they had received medicine training and had a good understanding of the differences between prompting and administrating medicines to a person and were clear on how this should be recorded on the medication daily record.

The service had a safeguarding policy which provided information about what constituted abuse and the actions to be taken if abuse was suspected. The policy provided clear guidelines and contact details for the local authority as well as the Care Quality Commission (CQC), if people or care staff wished to report to an external authority. Care staff that we spoke with had a clear understanding of what safeguarding was and the different types of abuse. One care staff told us, "Abuse is financial, physical emotional, verbal." The same care staff gave us an example, where they were supporting a person living with dementia; they overheard a conversation between the person and someone trying to sell something over the phone. Before the person could give any payment details over the phone the care staff began asking questions and at that point the person at the end of the phone disconnected the line. The care staff member told us that they immediately reported this to the relative of the person receiving care and also reported the same to the office.

Care staff knew what the term whistleblowing meant and knew who to report to if they had any suspicions that someone might be being abused. This also included reporting issues and concerns where they had observed poor practice by fellow colleagues. Care staff told us that they could contact the local authority, CQC or the police to report their concerns. One care staff told us, "About abuse, not being looked after properly. Different forms of abuse. Could be financial, physical. We need to look out for the well-being of the client. Make sure any abuse was reported. I would report it to the office first but if I was getting nowhere I would go to the local authority. I wouldn't leave it unshared."

People and relatives that we spoke with told us that they received a regular team of carers throughout the week and that they felt there was enough staff available as required. One person told us, "I have a regular carer and then others who cover holidays, I feel comfortable with all of them." Relatives' comments included, "We've no issues. We have regular staff and it's quite consistent" and "We have pretty much the same carers each time." We also asked people and their relatives to comment on whether care staff arrived on time for their call and whether the agency communicated with them when there were any changes. People stated, "Carers normally arrive on time." Relatives told us, "Yes. We've had no issues. They let us know if there are any changes" and "Yes they do. We've got contact details. They notify us if someone would be late."

The registered manager had recently introduced a recording book where all missed visits and late calls were recorded so that these could be monitored to ensure any emerging patterns could be identified and addressed with the relevant care staff.

The service had appropriate systems and processes in place to ensure the safe recruitment of staff as well as confirming their suitability to work with people. Care staff files that we looked at contained the necessary documentation including two references, criminal record checks, detailed recruitment history, identity verification documents which included passports, national insurance numbers and bank statements. Files also included evidence of the staff member's legality to work in the United Kingdom.

In addition to these checks the provider used a 'Right to work Checklist' which had been devised by the Home Office to ensure that as an employer they were obtaining and checking the appropriate documents from potential care staff as part of the recruitment process. The provider had also purchased a scanner, similar to those used at the airports, which enabled them to identify fake documents.

Good

Is the service effective?

Our findings

People and relatives confirmed that the care staff that supported them were well trained and skilled to deliver good, effective care. One person, when asked about whether they felt the care staff were adequately trained replied, "Yes, they are." Another person told us, "They are very competent." Relatives also provided us with similar feedback and statements that they made included, "Yes. Very much so. They've really got to know her as a person" and "Yes. No question."

All care staff recruited with the agency were required to attend an eight day induction programme. The induction programme covered training in all mandatory topics including moving and handling, safeguarding, health and safety and infection control. In addition to this the programme also provided training to staff on the 'Jewish way of Life', dementia, personal development and communication. Care staff that we spoke with and training records that we looked at confirmed that each staff member had attended the induction programme.

Training on the 'Jewish way of Life' looked at the religion as a whole and a number of aspects of the Jewish culture which care staff needed to be aware of. This included things like people not signing staff time sheets on the Sabbath and making particular adjustments on the day of the Sabbath, such as not using any electrical items within the person's home or not switching on the lights. Care staff also learnt a number of Hebrew words and phrases so that they were able to communicate and greet the people they supported.

Care staff as well as training records confirmed that each staff received annual refresher training in all mandatory topics such as moving and handling, safeguarding, medicine management and first aid. Care staff also felt able to tell their line manager of any additional training courses that they required to support them in their role. One care staff told us, "Training is much more in depth. You don't just watch a DVD. It's in the classroom." Another staff member told us, "There is good training and a lot out there that they offer. I requested further training on Parkinson's and this has been arranged."

Records confirmed that regular supervision was provided to all staff. However this had only become consistent over the last three months since the new registered manager had taken up the position. The registered manager had already identified this as an issue and had put measures in place to ensure that all staff received supervision on a three monthly basis. Another issue identified by the registered manager was the quality of the content of supervisions that the assistant managers were completing. The registered manager told us, "The assistant managers are supposed to supervise staff but I'm not happy with the content. I'm addressing this." We saw evidence that the assistant managers had been booked on training on how to deliver effective supervision and appraisal.

As part of the supervision process, all care staff also received annual observational supervisions which included a senior manager observing a care staff member whilst in people's homes. We saw evidence of the service informing people about observational supervisions taking place and the reasons why this was required. Prior consent of the person was also sought before an observational supervision took place.

Care staff told us that they felt supported in their role and received regular supervision from senior managers. One care staff member stated, "Supervision is if I want to discuss anything I can bring it up. How I'm getting on, any training. I've signed my supervision and it's in my file. I can have a copy if I want to." On one supervision recorded we noted a supportive statement that asked the carer, who was working with a person on palliative care, about how the care staff was coping with caring for the person and if they needed a break. We saw records confirming that care staff had received an appraisal and the registered manager had an overview in place stating when their next appraisal was due.

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

We checked whether the service was working within the principles of the MCA. The agency had policies and procedures in relation to the MCA. As part of the pre-admission assessment the agency did ask questions around capacity which were structured around the assumption that people had capacity and where someone lacked capacity, the agency had recorded where support was required and where a relative was involved their input had been recorded.

The registered manager and care staff demonstrated a good level of understanding of the MCA and how this impacted on the care and support that they provided. Training records that we looked at confirmed that care staff members had received training about the MCA. One care staff member told us, "It's about the person's capacity, what they can and can't decide." Another care staff explained, "Mental Capacity is where the person has no more capacity to make a decision. I would inform the office or the local authority and the family would be involved."

People and relatives told us that they had consented to the care that they received. Care plans that we looked at confirmed this. Care plans had been signed by the person receiving care and where they were unable to sign the care plan had been signed by a relative.

People were supported at mealtimes to access food and drink of their choice. The support that people received varied depended on peoples individual circumstances. Some people lived with family members who prepared and supported people with their meals. Some people lived on their own and so care staff would help prepare or heat up a pre-prepared meal and ensure that these people always had access to fluids throughout the day. People that we spoke with were positive about the level of support that they received with their meals. One person told us, "They [care staff] help me with my meals by cutting up my food. They always ask what I want eat and always make sure they leave me with a drink before they finish." Another person said, "I am 95 years old, and spend most of my time in bed, I am very happy with the carers, they make sure I am comfortable, have plenty to drink, and they always ask if I want a sandwich or a meal made."

Care plans noted people's likes and dislikes especially in relation to where a person required support with their meals. One person's care plan noted how they liked their food to be prepared and what staff should do to maintain nutrition. The care plan stated, "Carer to prepare and serve breakfast. During evening visits, carer to prepare, cook and serve dinner. Ready meals and ingredients to cook and prepare fresh meals are available." Care plans also recorded any culturally specific dietary requirements. Staff were provided with guidance on how meals were to be prepared and served. Once care plan stated, "[Person] receives kosher meals from meals on wheels daily for lunch. Jewish care to prepare meals and drinks for the evening.

[Person] is a very orthodox Jewish man. Carers need to promote a culturally sensitive service."

The registered manager and care staff were available to support people with their health care needs where required. People's care plans detailed people's health conditions and information that care staff would need to know relating to the condition. We also saw evidence of when the agency had made referrals to the GP, district nurses and other health professionals. For example the agency had made a referral for one person who required support with their continence.

Care staff knew the people they supported well and always recorded and reported any concerns or changes in people's health to the family where appropriate and the assistant managers at the office. Care staff knew who to contact if there were any concerns about people's medical health including emergency contacts. One person told us, "The carers would call the ambulance where needed. One time the carer had called the ambulance so quickly whilst me and my husband were still talking it through." One relative stated, "Yes. They'd phone me up if they had concerns." When we spoke with care staff, one staff member explained, "I would inform the family or I would call 999 if it was an emergency. If it was not urgent I would call the family to request the GP and then I would inform the office."

Good

Is the service caring?

Our findings

People and relatives were very complimentary about the service that they received from the agency as well as the care staff that supported them. People used words such as caring, friendly, competent and very good to describe the care staff that supported them. One person told us, "My carers are so friendly. They have become part of the family. In fact when I go to the day centre, if any of the carers are there they come over and speak to me." Another person told us, "When I came out of hospital I was very upset, I just didn't want to have care. The thought of carers in my home made me cry. But they have made it so easy for me I am very happy, I can maintain my independence with their help." Relatives, when asked if they found care staff to be caring replied, "Yes. Very. They are just kind. They make sure she's ok" and "Yes. The whole service and care experience. They're like family."

People's care plans were seen to be person centred and contained detailed information about the person including, their religion, their ethnic background, their preferred name that they wished to be addressed as, their likes and dislikes, an in-depth medical history as well as a detailed background history about their life and significant people and events that had played a part in the person's life.

A support plan was available with each care plan that we looked at, that detailed the level of care and support the person required. This included looking at the aims that needed to be achieved, how the agency was going to support the person to achieve the aim, who would do this and what the outcome would be. This level of detail provided care staff with clear direction and guidance on how care and support was to be delivered to people that they had been asked to support.

When we spoke to people using the service we asked them about whether they felt care staff knew them as a person and the support that they required. One person told us, "Oh yes! They are used to me now but they still do ask me if I need anything."

People and relatives confirmed that they were always involved in the planning and delivery of the care and support that they received. One person told us, "Yes, I am involved in the planning of my care. Relatives told us, "Yes we were. We discussed things" and "Yes. We work as a team." One example we noted as part of a review that had recently taken place was where additional support was requested by a family member. The entry stated, "[Person's] wife occasionally enjoys to go out in the evening so would like someone to pop in and see [Person] for half an hour whilst she is out. She will let the office know with plenty of notice." We asked the registered manager if this was happening and they confirmed that the service completed visits in line with this request.

During our visits to people in their own home, we observed that people felt comfortable speaking with one of the assistant managers that had accompanied us. People had established a caring and meaningful relationship with the staff member and it was observed that the assistant manager also knew the people we visited very well and was aware of their needs and requirements.

People and relatives that we spoke with and rotas confirmed that people received care and support from a

regular team of care staff. People were sent a copy of their rota on a weekly basis so that they knew which carers were due to support them. People and relatives also confirmed that if there were any changes, the office would inform them of those changes. One person told us, "I have a rota which tells me who is coming."

Care plans we looked at were person centred and focused on the person individual needs and requirements. As part of the inspection process we wanted to check care staff members understanding of what the term person centred care means. Responses received from care staff assured us that care staff had a good level of understanding of what this term meant. One care staff member explained, "Person centred care is all about the care that is focused on the person. Their likes and dislikes. Each person is unique. The care plan tells us the basic information and then we learn about the person as we go along."

Care workers were respectful of people's privacy and ensuring that their privacy and dignity was maintained at all times. Care staff told us that they gave people privacy whilst supporting them with aspects of their personal care. One care staff told us, When we are supporting people with personal care you should close the door and close the curtains. We have one person who has dementia who keeps removing their clothes. I make sure that I give them a gown to wear every time they do this." Another care staff explained, "I make sure that they are as covered as possible when I am giving personal care to maintain dignity and make it as comfortable as possible for them. Respect their wishes and if they can do something for themselves then we should let them. Listen and take on their views."

People and relatives also confirmed that care staff respected their privacy and dignity. One relative told us, "Yes definitely. They are very good." Another relative stated, "Yes. It works very well. Absolutely."

Good

Is the service responsive?

Our findings

The agency had a complaints policy in place and procedures had been set for receiving, handling and responding to comments and complaints. Folders that were held at people's homes also contained a copy of the complaints policy with a feedback form called, 'Remember your view counts', encouraging people and relatives to provide feedback. A complaints and compliments folder was in place which contained an overview of complaints and compliments that had been received between August 2015 and August 2016. In relation to the complaints, each record had details of the complaint and written notes of the actions taken and the outcome of the complaint.

We saw recent feedback forms that had been completed where compliments had been recorded. On feedback form stated, "I would like to thank the homecare office for sending me such a lovely worker today. She was just lovely and very good at everything."

People and relatives told us that, at present, they did not have any complaints, issues or concerns to raise, however, they felt confident that if they did have any concerns or issues, they knew who to speak with and were confident that these would be resolved. People told us, "I feel comfortable to complain and know who to speak to" and "If I had any concerns or complaints I would call the office immediately." When we asked relatives about lodging a complaint, feedback we received included, "Yes. (We have contact details) But I've not had to" and "Yes. We have a folder with information on it."

People and relatives confirmed that their package of care had been planned and delivered in partnership with them and their relatives where appropriate. Care plans contained evidence of a pre-service assessment that had been carried out prior to any package of care being introduced to ascertain whether the service could meet the person's needs. The assessment contained information about the person, their personal details, a health and medical history, a summary of needs as well as a background life history of the person. The assessment also included details of the person's religious beliefs, food and drink preferences and likes and dislikes and how they wished to be supported.

All pre-service assessments were mostly carried out by the assistant managers who would then have responsibility for devising the care plan and co-ordinating the care package. Each assistant manager would then continue to be the key contact for the person and their relative that they had assessed. This ensured that people and their relatives had a familiar, known person who knew their needs, whom they could maintain regular contact with about the person's care and support needs.

Once the service started and the care plan was in place we saw evidence that these were reviewed on a regular basis. The registered manager or one of the assistant managers carried out three monthly reviews or more frequently depending on the needs of the person and the support they received. We saw evidence that people and their relatives had been involved with the review process and review documentation had been signed either by the person receiving care or their relative. One person, when asked about the review process told us, "Yes, my care gets reviewed regularly." One relative told us, "Yes. They did a review. It went well. We talked through things and it went well, we are very happy."

Another example that we noted, following a review it was recorded that the person was becoming frail and required extra time at the morning visit to ensure care was completed. We saw evidence that this was responded to by the service and the time allocated was increased. The person's care plan had been updated to reflect this change.

People received personalised care that was responsive to their individual needs and preferences. Care plans clearly detailed people's needs especially in relation to their religion and culture. For one person, their care plan detailed how their dietary needs were to be adhered to as they only followed a kosher diet. The care plan stated, "Dietary / cultural needs, '[Person] is strictly kosher and has separate milk and meat cupboards in the kitchen. [Relative] has labelled the cupboards." For another person, their care plan provided guidance to staff on how a person would like to be dressed to attend the synagogue and how they would like to observe the Sabbath. The care plan stated, "'Ensure [person] appropriately dressed for the synagogue. Head covering, long skirt. After the candlelight on a Friday evening mundane household activities will not be done. Ensure all these are taken care of before the Sabbath. It is also forbidden to use any electrical appliances."

As part of the delivery of care and support, care staff completed daily record notes detailing the time they started providing care, the time they left and details of the support provided throughout the duration of the call. We looked at a sample of daily record notes and found them be basic in detail and only recorded the tasks undertaken and did not record any information about the person and their wellbeing. However, for those people who received a large package of care and where the care staff were present with the person for long periods throughout the day, activities that the person had taken part in were recorded. The care plan for one person noted, "Activities, on a good day, weather permitting, carer to take [person] for a walk or to the park. Stimulate [person] by chatting to her about her interests such as the news, art and play games. Escort [person] to visit family, to the synagogue and for shopping." Daily recording notes also confirmed that activities were taking place. One relative when asked about involvement with activities told us, "Yes she does. She gets to do things that she wants to do and things she needs to do."

The agency ensured that they observed all religious events throughout the year as well as celebrating people's birthdays. For religious occasions Jewish Care devised celebration cards which the agency sent to all people and relatives receiving care and support. The same applied for when it was a person's birthday. The agency would ensure a card was sent to the person on the day of their birthday.

We observed staff treating people with respect and as individuals with different needs and preferences. Staff understood that people's diversity was important and something that needed to be upheld and valued. One care staff when asked about supporting a person who identified themselves as being lesbian, gay, bi-sexual or transgender told us, "It wouldn't make any difference either way to me." Another care staff told us, "I am providing care for a person regardless of their gender or sexuality."

Good

Is the service well-led?

Our findings

People and relatives told us that they knew who the registered manager was and felt confident in contacting them and the team if and when the need arose. One person told us, "I have met [registered manager], She did a review with me." Another person told us, "The manager is [name], I have met her once. She is very approachable." Relative's feedback was also very positive and comments included, "I have met a number of senior people. [registered manager] is great" and "Yes. They came to visit before the service started, and at the review. They're very good and they let us know if there are any changes/developments."

Assistant managers and care staff that we spoke with were also very positive about the registered manager as well as working for the service. One assistant manager told us, "The registered manager is very supportive. If I have any problems I can go to her. She is very approachable. I feel I have been learning quite a lot from her." Care staff members told us, "[registered manager] is lovely. She's approachable and makes time to hear you out. She makes you feel welcome to talk, even if it's a minute problem. Very warm and I'm not afraid to approach her" and "I like working for Jewish Care, it's a nice organisation."

Care staff told us and records confirmed that regular team meetings were held throughout the year. In the past these meetings were held on a quarterly basis but most recently, since the new registered manager has been in post, team meetings have been held on a monthly basis. Agenda items included, staffing issues, client surveys, spot checks and clients issues.

The registered manager had also introduced regular monthly meetings with all senior and office staff members. These meetings were recorded and topics discussed included complaints, compliments, assessments, safeguarding and medication risks.

The registered manager had systems and processes in place to check and monitor the provision and delivery of personal care and support. These included systems to monitor when a person's care and support package was due for review, an overview of when staff supervisions and appraisals were due, records of late and missed visits, observational supervisions, weekly telephone monitoring and unannounced spot checks. Assistant managers also attended care shifts themselves, where required. This gave them an opportunity to quality assure the level of care the person was receiving as well as assess that the level of care was appropriate and note if any changes were required.

We looked at the records of late and missed visits. The service recorded the details of any missed calls or late visits and also recorded the action they had taken. Where this included addressing issues with a particular care staff member, this was recorded on the computer rostering programme which listed each care staff and had a notes section that the service used to make notes so that any emerging patterns or issues could be easily identified and then addressed formally through supervision.

The agency had a stand-by system in place at weekends where two or more care staff were allocated a stand-by shift and would be available to attend to any last minute cancellations to ensure that people received the care and support that they required. This also ensured that there were no missed visits to

people who required care.

The service carried out annual quality assurance surveys. People and relatives confirmed that they had received questionnaires to complete. Some people told us that they were often telephoned by the agency and asked how their care was going and if they were satisfied with their care. We saw the results for the survey carried out in 2015. Feedback received was positive. Results and feedback received was compiled into an evaluation report which was distributed amongst managers with a view to addressing any emerging issues or concerns and making improvements to overall service provision.

All staff at the agency were also asked to complete an annual staff survey which asked open questions about how staff felt working for the agency and what changes they would make about working for Jewish Care. This gave care staff the opportunity to give feedback and make suggestions for improvements.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People using the service were at risk because the service did not assess and mitigate individual risks identified as part of the care and support plan.