Agudas Israel Housing Association Limited

Beis Pinchas

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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 12 and 15 July and was unannounced. At our previous inspection in April 2015 we found breaches of regulations relating to the management of medicines and safe care and treatment. At this inspection, we found that the provider had made improvements and was now meeting these regulations.

Beis Pinchas is a care home with nursing, which is registered to provide accommodation to up to 44 people. At the time of our inspection the service was fully occupied. The service provides support to older men and women from the Orthodox Jewish community. Beis Pinchas is a four story, purpose built building with communal facilities including a day centre, dining room, sensory room and a newly built spa area. There was a large synagogue which is also used by the local community. It shares facilities with the supported living service next door, which jointly forms Schonfeld Square Care Home. All rooms have an ensuite shower, and each floor has shared bathrooms with lifting baths and hoists.

The service had a registered manager. 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.

The building was clean throughout, well decorated and well maintained, and provided a safe and accessible environment. Communal areas were large, bright and airy, and featured a computer room, an indoor sensory garden and a large dining area. A 24 hour security guard ensured people were safe.

Risks to people were appropriately assessed and plans were in place to manage these risks. Care plans for people had detailed information about their needs, wishes and life histories, and provided staff with enough information to deliver personalised care. The provider had recently introduced an electronic care notes system which ensured that important information was seen by and recorded by staff, and allowed long term trends in people's health and needs to be observed. This system aided the delivery of co-ordinated care, for example by automatically generating information to be handed to hospital in the event of an admission. The same system was used to record people's wishes about end of life care. Medicines were safely stored and administered by the nursing staff, who provided strong and confident leadership.

The provider took care to ensure that meals were of a high quality, nutritious and compliant with Jewish law. People who needed support from staff to eat received this with patience and dignity. Where people were at risk of malnutrition, staff assessed this and recorded people's food and fluid intake and monitored people's weights appropriately. Staffing levels were adequate to meet people's needs, and the service also benefitted from a team of volunteers who provided additional support to people. There were robust and safer recruitment processes in place for staff, and processes in place to ensure that nursing staff were appropriately registered. We noted that the provider had difficulty retaining staff in some cases, which was a source of dissatisfaction to some people we spoke with.

There was a comprehensive and varied activities programme in place, this included visits out to places of interest and typically six activities a day in the communal areas of the building, including talks, exercise groups and music. These were well attended and very popular with people who used the service. Many of these activities were based around Jewish culture and beliefs, which was integral to the way the service was run, and showed strong links with the local community. Staff received frequent training and instruction on how to meet people's cultural needs. People were dressed appropriately in their chosen clothes and their dignity and privacy were respected. Staff used people's preferred terms or address and knew their wishes and preferences well. We witnessed many kind and caring interactions from staff, and frequently observed friendly conversation and laughter.

Staff received appropriately levels of training and supervision to carry out their roles, which was monitored by managers. Managers maintained robust and detailed systems of audit and had a strong presence in the service in order to ensure high quality and person centred care. People's views were taken into account by managers through regular engagement, and when people had made complaints these were investigated and dealt with appropriately. People's consent was obtained to their care in line with legislation, and when people were deprived of their liberty the provider had taken the appropriate steps to ensure this was in their best interests.

The service had successfully delivered a detailed plan to improve the service since our last inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The environment was well-maintained, free from hazards and secure. Risk assessments gave adequate information on how to manage risks to people, and there were personal emergency evacuation plans in place.

There were adequate numbers of staff, who had been recruited in line with safer recruitment processes.

Medicines were safely stored and administered by nursing staff.

Is the service effective?

Good

The service was effective.

Staff received extensive training and supervision to ensure that they had the appropriate skills to carry out their roles, which was monitored and managed effectively.

The provider was meeting its responsibilities to ensure people had consented to their care, and that when they may not be able to do so their capacity was assessed and the staff acted in people's best interests. The provider had appropriate authorisations in place for when people may be deprived of their liberty.

Food was served with care and consideration in line with Jewish dietary requirements, and was of a good quality. People's weights and food and fluid intakes were monitored when necessary. People were supported to attend health appointments and maintain good health.

The building was well designed to meet the needs of older people and people with dementia.

Is the service caring?

Good

The service was caring.

People told us that they were treated with kindness and respect

by staff.

There was a rich and varied programme of activities which was popular with people who used the service and was culturally appropriate. Staff were informed about people's needs around religious holidays.

People had end of life care plans, which clearly stated their views and wishes around death.

Is the service responsive?

Good

The service was responsive.

A new electronic care notes system had been implemented which allowed clear and relevant information to be added to people's records. There was sufficient information available on people's care needs, likes, dislikes and daily routines.

There was regular engagement with people who used the service and their relatives and the provider had acted on people's comments and suggestions.

People knew how to complain and were confident the provider would take complaints seriously. Complaints were recorded and investigated appropriately.

Is the service well-led?

Good

The service was well led.

The registered manager had detailed and robust systems of audit. The registered manager and Chief Executive were closely involved in the running of the service, and ensured a positive, caring culture.

Regular team meetings ensured that staff were aware of people's needs and the provider's policies and requirements. A detailed action improvement plan had been implemented since our last inspection.

Beis Pinchas

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 12 July 2016 and was unannounced. We returned on the 15 July to complete our inspection; the provider knew we would be returning. The inspection was carried out by a single inspector, who was supported by a specialist professional advisor who worked as a nurse, and an expert 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service, including notifications of significant events that the provider was required to tell us about.

In carrying out this inspection, we spoke with seven people who used the service and two people who were visiting friends or relatives. We spoke with the registered manager, the CEO of the provider organisation, three registered nurses, two care workers, the housekeeping manager, a laundry assistant and the social affairs co-ordinator. We also spoke with three health professionals who were visiting the service including a GP, psychologist and community pharmacist. We carried out observations of activities, lunch, moving and handling, direct care and social interactions.

We reviewed 13 files relating to people's care, and four staff files. We also looked at records relating to the management of the service, such as audits, rotas, records of training and complaints.

Good

Is the service safe?

Our findings

People who used the service told us that they felt safe. One person said, "Yes, I feel safe, they are very careful with staff selection", and another person said, "There's security and staff about all the time." Access to the building was managed by a 24 hour security guard who was positioned between two locked doors and there was a staff reception facing the front door.

All staff had had recent training in safeguarding adults and children. Staff we spoke with were knowledgeable about signs of possible abuse, the types of abuse and their responsibilities to report any concerns. One staff member said, "If I saw anything that needed reporting I would do what I have to do, starting with my immediate manager and going through the stages until I knew it was being dealt with." Whistleblowing was discussed in staff meetings, and the provider told us they had opened a social media page for staff and were using this to post information on safeguarding responsibilities. Another staff member said, "If I saw a problem that required whistleblowing I would report without hesitation. There is no doubt it would be taken very seriously." When safeguarding concerns had been raised, these had been recorded and managers had logged that the appropriate actions had taken place, including an immediate action plan and that the local authority and CQC had been informed.

The fire and evacuation procedure was displayed throughout the building, and personal evacuation plans were in place and reviewed regularly. These were clear, and colour coded with the levels of assistance required to evacuate safely, including a photograph of the person. There was a map of the building which was colour coded to indicate the level of support people would need to evacuate, and highlighted other risks such as oxygen tanks. We saw that checks were carried out weekly of the fire alarm.

A person who used the service told us, "Things are in place to avoid falls." We saw that all bedrooms had en-suite facilities, with a range of fixtures and fittings to aid safe movement, such as handrails. There were also spacious bathrooms with a range of lifting hoists. Hoists and wheelchairs were clean and in good working order. Padded bedrails were extensively installed throughout the building, on automated beds. Staff told us that there was adequate equipment to meet people's needs. We saw that people who were unable to leave their beds had pressure mattresses in place. A single member of staff, the procurement officer, was responsible for all equipment checks, and had carried out an audit in February which showed that all equipment was appropriately maintained. The registered manager had also carried out an audit in February to ensure that pressure mattresses were maintained, in good condition and set to the appropriate setting for the person who used it.

There were no visible trip hazards, and flooring was suitable and well maintained. We observed that a carpet on the first floor landing was becoming worn and may become a trip hazard; the provider told us that they had a rolling maintenance programme which involved replacing this in the near future. Corridors were clear of obstacles and doorways were wide and clear, with handrails fitted to both sides of the corridor. Floor areas were uncluttered and had plenty of space for manoeuvring. Staff were patient and careful when moving people in their wheelchairs. A lift was in place, which ensured that access to all areas of the building was step free.

There were open plan sitting areas and a dining room which offered good opportunities to observe people and these were supervised by staff. When people summoned attention directly or via call alarms from bedrooms, staff responded promptly. The registered manager demonstrated the different tones which demonstrated the priority of the call, and told us that a call becomes a priority after three minutes. There was a separate call system in place which people could use during Shabbos, during which certain tasks including using electrical equipment are prohibited. People who were in their rooms were visited at least hourly, and a rota indicated which staff were responsible for carrying this out. We saw that all staff were carrying radios, and a staff member explained, "If I'm assisting someone and I need help, I can use the radio and don't have to leave the room." Staff were also able to use these radios to ensure that only the correct number of staff came when help was needed. We saw examples of supportive teamwork during our inspection.

Staff had yearly training on moving and handling, and demonstrated skilled moving and handling techniques when transferring people. Hoists were used appropriately and staff communicated with people what they were doing clearly, and worked in pairs as required. We observed that when one person was having difficulty mobilising with a frame, was becoming distressed and at risk of falling, staff responded quickly, reassured the person, assessed the situation, agreed a plan and transferred the person temporarily to a wheelchair. A staff member later told us, "We get good training on lifting and handling and it is updated yearly. We work in twos to maximise safety and comfort for the residents."

Risk assessments were comprehensive in their scope and reviewed regularly. The system used to generate these had only recently been introduced, but clearly showed how many staff were safely needed to support a person, and how the risk had changed with time. When people had behaviour which may challenge the service, a risk assessment gave clear guidance for staff and volunteers on how to manage the risk. For example, a risk assessment stated that a person who could be physically aggressive should be supported by male staff. When people were at risk of falling, we saw that there were management plans in place. A falls action plan had detailed instructions on how to support a person when they were moving, and factors which could increase the risk to the person such as becoming out of breath.

We saw that accident and incident forms were completed when required. The registered manager had responsibility for completing these in consultation with staff, and had followed through on actions, recommendations and any changes which had been required as a result of the incident. The provider undertook a yearly review of accidents and incidents, which identified peak times for accidents occurring, and made recommendations for the service, such as ensuring that staff did not take their breaks at the same time, and to provide extra staffing at times when routines may be interrupted, such as during religious festivals. Managers told us that they had brought in additional staff at the mid-morning period, when a higher number of accidents had been observed during the year. Abrasions, bruises and skin marks or tears were recorded, dated and signed off methodically, although body maps were not always precise in terms of the location of the injury. In some instances, incident forms did not verify that people had not suffered injuries as a result of behaviour that challenged.

Staff worked as keyworkers to people who used the service, on a 12 hour shift system. Staff allocations were clearly displayed on a daily basis, and staff wore uniforms and were smartly presented in accordance with the dress policy. A bank system was in operation for ensuring that the provider was able to cover short notice absence, and on rare occasions if nursing staff were busy or short staffed the registered manager was supportive and assisted personally if required. Agency staff were not used.

Staff told us that staffing numbers were adequate to meet peoples' needs. We reviewed two weeks of rotas, which showed that there were additional staff in the morning, and that there were never more than three

people for each member of staff. There were always three nurses on duty during the day time. At night, we saw that there was one nurse on duty, along with two male and two female care workers, which was adequate to ensure that people could be supported with personal care.

The provider told us that they struggled to retain staff, and explained that staff from overseas were often overqualified for their roles. One person told us, "As soon as you get used to one person they leave and new one comes. I appreciate my male carers very much but I wish they were better retained."

Safer recruitment processes were in place. We saw that all staff were interviewed and assessed by the CEO of the provider, and that suitable identification and proof of address had been seen and a copy retained. The provider collected and monitored information to ensure that equal opportunities were promoted during the recruitment process. The provider had obtained a complete work history for people without any gaps, and had obtained two work references. All staff had had a check with the Disclosure and Barring Service (DBS) prior to commencing work. The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions. We noted that although all staff had been recruited in line with safer recruitment processes, the provider did not have a process in place for verifying that all stages of this process had been carried out.

The provider told us that they were planning to require staff to repeat their DBS checks every three years, and maintained a record of the date of the staff member's last check and when their next one would be due. Of the 69 staff working in the service at the time of our inspection, the provider had identified 10 staff who had a DBS check which was more than three years old which were to be repeated.

We saw that the provider maintained a system for ensuring that there was an up to date PIN to ensure that nurses were still registered to practice. We verified these PINs against the Nursing & Midwifery Council (NMC) register.

All staff, including cleaning staff, had received infection control training. We observed that there were hand sterilisation points in place, and potentially infectious waste was appropriately disposed of. All areas of the building we saw were kept clean, and furniture appeared as new and in good condition. The registered manager had carried out an infection control audit, which had identified and addressed minor points for improvement. Health and safety checks were carried out regularly, and the provider had carried out yearly checks of electricity, gas, portable appliance tests and water checks, including testing for legionella.

The clinical room was well managed and all records were up to date. Temperatures were appropriate for storing medicines and controlled drugs were correctly stored and recorded. Other drugs were also appropriately stored, although additional cupboard space would have allowed a better layout of boxes and bottles, which would make them easier to arrange and locate.

Medicine dispensing trolleys were appropriately stored in the clinical room when they were not in use, and were safely locked if the nurse was diverted from the trolley whilst dispending medicines. medicines recording charts (MRCs) were properly maintained, correctly completed and were easy to follow. Warfarin administration was carried out in line with documentation, which was checked and signed by two nurses and confirmed by the community pharmacist. Controlled drugs were similarly strictly recorded, and used patches were disposed of safely and securely. Where people needed them, pain monitoring charts were in place using the Abbey pain scales, which was kept on paper records alongside the MRCs. Nurses we spoke with gave a good account of how they would assess and control pain for a person with advanced dementia.

Medicines folders had photographs on the front, which reduced the risk of medicines being wrongly

administered. Correspondence relating to medicines regimes were filed alongside MRCs, such as examinations and scans of swallowing reflexes. Speech and language therapists were also regularly consulted when people had swallowing difficulties.

We observed nursing staff administering medicines to a person with severe disabilities, and saw skilled patient communication. The nurse used skilled positioning in bed, and took time to assess their general welfare and any other care needs.

People requiring crushed tablets had individually named pill crushing pots. Nursing staff were aware of the importance of checking and avoiding residue collecting in pots. The community pharmacist told us she advised on who had swallowing issues which might mean people needed their pills crushed and advised on what could and could not be crushed. Night staff also cleaned these devices as an extra precaution. GPs were consulted regarding best interests decisions and peoples' capacity to consent in this regard. The pharmacist visited regularly and gave advice, for example changing medicine times in order to improve concordance. The provider told us they intended to move away from the blister pack system and improve the overall efficiency of medicines rounds. MRCs were audited every Saturday for accuracy, discrepancies and other issues requiring special attention. All nursing staff had received appropriate training on administering medicines.

Nobody was receiving covert medicines, but staff were aware of the procedures to follow should such a care plan be required. The provider told us that there was nobody who was self-administrating their medicines, but they had carried out a risk assessment for one person who wanted to try it, but had decided not to.

Good

Is the service effective?

Our findings

People received care and support from staff who had the skills and knowledge to meet their needs effectively. Nurses assumed leadership roles with ease and confidence. They worked methodically and prioritised as required. They coordinated and offered support to other staff. Nurses told us that their training was comprehensive and up to date. Training for nurses included medicines, fire safety, first aid, infection control, safeguarding, COSHH, cardio-pulmonary resuscitation, dementia care, food hygiene, health and safety, mental capacity, moving and handling, PEG feeds and risk assessment. Only one staff had gaps in their training, and this person had recently joined the service.

We saw that training was being run on the day of our visit on inhalers, and that staff were scheduled to attend other sessions during the week. Prior to starting work staff had a competency test, including observations of their practice and a written test which required them to look at a sample medicines chart and detect errors. The provider had systems in place for recording staff training and detecting when training was due for renewal. We saw samples of comprehensive training documents and certificates of attendance.

Care workers had also undergone training in the last 18 months on COSHH, dementia care, diversity and equality, fire, first aid, food hygiene, health and safety, infection control, manual handling and safeguarding of adults and children. A small number of staff had not fully completed areas of their training, we verified that this was either due to staff having recently started with the service, or recently returned from maternity leave. The provider told us that on returning from maternity leave, staff were required to restart their training from scratch. We noted that there was also mandatory training for non-care roles, for example domestic staff had mandatory training in COSHH, fire safety, health and safety and manual handling, and administrative staff had training in fire safety, health and safety, manual handling and safeguarding adults.

Nurses facilitated supervision sessions for care workers and the records showed regular training was happening at least every two months. Supervision calendars were up to date and meetings were planned for the entire year. There was also a reminder poster indicating who was due supervision in July, and names were ticked off when complete. Annual appraisals were also timetabled, and one new member of staff was due to have a first appraisal within three months of joining the service. Supervision notes had easy to follow categories to cover within supervision meetings, with scores of staff performance ranging from 'Excellent' to 'Unacceptable'. Staff signed off their records as agreed.

The provider was meeting its responsibilities in line with the Mental Capacity Act (MCA) 2005. The Act 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. Care plans showed that where people lacked capacity their relatives were present in best interests meetings when assessments were completed where appropriate. Where a person had a Power of Attorney, this was documented on the file. Consent forms were completed and people with capacity to do so had signed these forms and their care plans. Where staff identified that people may not be able to make a decision, for example with regards to the

use of bed rails, a mental capacity assessment had been carried out. These were consistent with the MCA, and clearly documented which decision this related to, included a two stage assessment of capacity and documented the outcomes from the assessment. Staff understood their responsibilities to assess people's capacity and understood the MCA well.

Several people who used the service were potentially deprived of their liberty, either through not being able to leave the building or through the use of bedrails. 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 that the provider had met its responsibilities to apply to the local authority to deprive people of their liberty and to notify CQC. Files we examined showed the appropriate documentation was in place, and that dates of expiry were clear. These had been recently audited, and one authorisation was due to expire, which the registered manager was already dealing with. Although the front door was locked, there was a 24 hour security guard in place who could let people in and out of the building.

We saw that staff were using food and fluid charts to document people's intake when it was identified that they may be at risk of malnutrition. Staff told us that one member of staff was in charge of recording this, and kept paper records which were then transferred to people's electronic care records at the end of the meal. One person told us, "When they weigh me and I've put on weight, they tell me to be more careful." There was clear information available for staff about who would be needing food brought to their rooms, and who had specialist dietary needs including thickeners, which drinks people preferred and if they would be needing jugs or straws. One person said, "I'm allergic to one food and they make sure I don't get it."

Meals were served in the large dining room, with food served from the kitchen and taken on trays to people. Tables were pleasantly set with tablecloths, cutlery and napkins. Several people confirmed that the food and dining room experience was very popular. One relative told us, "It is like a hotel and the residents love it. Just looking at the table preparation tells you how much attention to detail matters."

Catering operated in accordance with Jewish Kashrut law, prohibiting combination of dairy and meat (Milchig and Fleishig) products. This demands special dividing arrangements for the kitchen where foods are stored, prepared, cooked, transported and served, and separate washing up of dishes and cutlery. Staff were knowledgeable and commented that they had good training in this aspect of care delivery. The result was a demonstration of teamwork delivering an unhurried and considerate service.

Food looked appetising and there was an extensive range of choices over a four week menu rotation. One member of staff said that the food was: "stunningly good". We noted that food was of a good quality and vegetables were cooked in order to preserve nutrients and texture and the food was suitable for the time of year. On a hot day one of the options was fresh fruit salad. People were offered fresh lemon tea after lunch. Everyone we spoke with was happy with the food. One person told us, "I adore it".

People who had difficulty with communication or co-ordination were supported and encouraged to eat independently if required. This was done patiently and respectfully. On both days we observed one person being supported by a staff member to eat over a period of an hour. Throughout the meal the staff member asked if the person was happy with the food, if they wanted more, or if they wanted something different. Care workers asked people if they wanted to wear aprons for the meal, and placed them on people if they gave permission. We saw that a staff member identified that the person they were supporting did not like wearing an apron, and this was taken off. We observed that staff listened to people who used the service. For example, one person requested water for herself, and a friend, and for her friend's water to be ice cold, which staff did.

The Chief Executive told us, "We have a rule here that when we get to an appointment, it's important to bring kosher food as people may not have this."

People told us that they were supported by staff to attend health appointments. One person said, "Yes, they take care of that when I need it." We saw many examples of people attending health appointments with staff support. The service was also visited by a GP, who told us that the quality of care was very good, and from a nursing perspective "excellent." The electronic care notes system was used to generate a hospital admission pack, which ensured people received co-ordinated care on admission by providing hospital and ambulance staff with detailed information about people's health needs and medicines. The pack also included a list of people's current medicines, with a note giving the date it was last updated. The provider showed us the handwritten form they had previously completed on calling an ambulance, and told us, "We can spend the time this saves us on checking the medication is right."

The building was well designed to meet the needs of older people and people with dementia. We saw that people had their names and frequently pictures on their doors, and there were many visual cues which would enable people to navigate around the service. The building had an indoor sensory garden, which included fish and birds, and an outdoor sensory garden, with scented flowers laid out in the shape of a menorah. Access to all areas of the building was step free. The provider had recently installed a sensory room, with immersive projectors in order to aid people's recollections and relaxation, but told us they were still learning how people preferred to use this facility. There was a dedicated hairdresser, with a member of staff who was also a hairdresser and was experienced in caring for people's wigs. The provider had recently built an extension including a spa with a Jacuzzi room, and during the course of our visit we saw many people being supported to use this facility.

Good

Is the service caring?

Our findings

People told us that they felt treated with respect by staff. Comments included, "People are friendly, they listen to what I have to say", "They're very helpful, I have a particular carer that I like and if they do anything I don't like I tell them", "They are very friendly and try to do what I need", and "They all respect me and call me Mister." A relative told us, "I am very grateful my father is here."

The general atmosphere in the service was calm and industrious. Staff spent minimal time on administration and mostly on contact with people. They showed considerate attitudes and addressed people by their proper names. People with dementia and limited verbal communication skills still benefitted from meaningful interactions with staff. The importance of attitude and communication was regarded very highly by all grades of staff from the Chief Executive Officer (CEO) through to the domestic staff, and high quality service delivery was a recognised part of the culture.

Staff communication with people was warm and friendly, showing caring attitudes whether conversations were outwardly meaningful or not. They took opportunities to sit beside people and chatted when they had time and people were referred to by preferred names. At meal times staff displayed patience, especially with the slowest eaters. One person with physical disabilities had a pureed meal nicely arranged on the plate and once finished was assisted at his request to have a cigarette outside in the smoking area. We noted that the smoking area did not have a canopy cover so that people were protected from bad weather whilst they were smoking.

People's personal clothing and bedding was laundered in-house. This six day a week service was well managed and incidents of clothing getting mixed up was minimal. Clothes and sheets were observed being prepared for transporting back to bedrooms, with some items being steam pressed and hung on hangers. A local laundrette was used as an option for special materials. One person requested their whites were kept separate and this was followed by the care staff and laundry assistants.

There was a rich variety of activities throughout the week and these were displayed in colourful adverts in prominent places throughout the home. Arts and crafts materials were in good supply in the sitting area and several people were seen using these. The service enjoyed visits from local schoolchildren who put on small concerts. People also had access to computers and were supported to learn IT, using it for contacting distant relatives and friends via Social Networking, and Contact with New York and Israel were particularly popular. Other people used personal iPads. There were recreational and faith facilities, including a Jacuzzi and library. An in-house synagogue held services three times a day, and this was used by the local community. There were many pictures of events displayed in communal areas, including guests from the local community, school groups and VIPs.

There were usually six activities a day and these were very popular. We found that many people were too occupied with activities to speak with members of the inspection team. We observed a seated exercise session which was attended by half the people who used the service. This was effective and worked on all parts of the body. The instructor engaged well with people and ensured that people were doing exercises

correctly. People who took part appeared to enjoy this.

A large proportion of the activities were related to the Jewish faith, for example prior to Shabbos a violinist gave a performance called "Welcoming the Shabbos", and a service was held afterwards. We witnessed a talk by a visiting speaker about aspects of Jewish life which was engaging and well attended by people who used the service. Morning prayers were offered on weekdays by the Rabbi, and we saw that a programme had been arranged to mark the festival of Shevuos, which had recently taken place. We noted that prior to a religious festival, a team meeting had taken place which had clearly explained to staff who may not be Jewish what the festival meant and what they needed to do to support people appropriately at this time, for example in terms of food, clothing and other traditions. A staff member said, "Every month we have a meeting explaining what is the holiday. We're working in a Jewish community, we have to respect religion."

The social affairs co-ordinator had a good understanding of the practicalities of arranging engaging activities and was enthusiastic about her role. For example, when school children had visited for a performance, one person was reluctant to engage, so she had given her the job of handing out sweets which had encouraged her to take part in the activity. The co-ordinator told us that birthdays were amongst the highlights of the service, and that when people did not have families involved they encouraged people from the local community to "adopt" the person and visit them on special occasions. The co-ordinator told us that they had used community art schemes to give people access to musical performances, and that they had arranged for the Wallace Collection to bring items from their collection for people to see. The co-ordinator said, "There are beautiful people who can't go to museums."

People's bedrooms were personalised and many people had photographs of relatives and friends. One person's room had accessible information displayed about the day's weather, and had their named nurse and keyworker's names displayed.

We saw that a range of volunteers regularly visited the service, helping out with social interaction and at meal and tea times. Volunteers were particularly involved at religious festivals and in the lead up to Shabbos, and were highly regarded and respected by the permanent staff. One person who used the service also worked as a volunteer, with responsibilities such as running the trolley shop, showing people around the building and sending out post.

People told us that they felt they were listened to and had choices. One person said, "Yes, they listen because they do as I ask", and another said, "I was asleep and I didn't want to get up, and they respected my wishes showing me that they listen." Staff told us they understood how to protect people's dignity, for example asking people if they preferred a shower or bath, ensuring that doors were closed and that people were covered with towels when giving personal care. People who used the service told us that staff always knocked before coming into their rooms. One person said, "They are very respectful", and "When I'm being helped to dress the door is kept closed."

The provider told us that they had started to instigate the Gold Standard Framework, which deals with end of life issues, however they had withdrawn from this as it was not compatible with Jewish beliefs about end of life care. There were no people receiving end of life care at the time of our inspection, but staff we spoke with had the knowledge and skills to implement this as required, and would refer people to the palliative care team at the local hospice. One staff member said, "We have advance care plans in place, we sit down with residents who have capacity and find out what their views are on their care and resuscitation." Care plans had detailed information about people's wishes for end of life care, and stated that they would prefer Jewish values to be upheld with all decisions made about end of life care. The provider told us families were often reluctant to discuss end of life care when death was imminent. A visiting health professional told us

that discussions of end of life care could be difficult in Orthodox communities, but that "the problem is not the service, they do their best to respect this." Where DNACPR (Do not attempt cardio-pulmonary resuscitation) forms were in place, professionals and relatives had been appropriately consulted and signatures were obtained. A relative told us, "They are very well trained to deal with the situation and I am very happy with how they handle things. As much as it is humanly possible, they do the best they can and consider your wishes."

Good

Is the service responsive?

Our findings

People told us that they felt involved in their care plans and knew the contents. One person said, "They do their very best to look after me how I want and need." A professional visitor to the service told us, "They try to be very person centred."

We saw that care plans contained life stories and personal information, including information on people's families, occupations, life histories. There was also information about people's likes, dislikes, daily routines and preferences with regards to care staff. The provider had implemented and introduced an electronic system for managing care files at the end of last year, and care plans were in the process of being transferred to this system. Those in the more advanced stages were seen to be person-centred and informative. The system appeared user-friendly, comprehensive and the range of the subdivisions was easy to follow. A useful traffic light indicator alerted staff when progress notes were due for updating. Most notes had a green light and the registered manager told us that any due for updating would be attended to during that shift. The system required entries twice in each 24 hour period. The computer was kept in a communal area with secure password entry, meaning that staff could complete this whilst still being with people. One member of staff told us, "I'm so happy with it, it's so easy and practical."

Progress notes also had useful one-word summary flags. This gave useful speedy identification of trends. Examples in use included 'Happy', 'Irritated', 'Calm', 'Satisfied'; 'Frustrated', 'Worried', 'Content', 'Enjoyed'. Similarly, there were useful thumbs up and thumbs down icons giving a quick reference list of peoples' likes and dislikes such as food, daily routine and activities. Risk assessments had clear records of what the trends were with regards to people's changing support needs, although there was limited data available due to the system's recent implementation.

The provider told us that this information was stored locally and also backed up using USB sticks. We saw that in the event of system failure, care plans and essential risk assessments, as well as hospital admission information, was printed and stored on people's care files.

The provider had an adjacent associated service which was comprised of self-contained apartments. We saw many examples of people who had transferred to the care home from this service as their needs changed, which allowed people to maintain their social contacts and their sense of belonging to a caring community.

The provider had introduced a suggestion box, which was kept by the door and checked twice weekly. Records showed that that the provider had taken action in response to these. For example, one person had suggested the service should have a 24 hour reception, and this was put in place a month later. Another person had suggested that the stairs needed to be more brightly lit, and managers had investigated this and found that there was a light bulb missing which had been replaced.

There were meetings taking place every three months between people who used the service, their families and staff. These were always chaired by the Chief Executive. We saw that areas were discussed including

staffing, the condition of the building, and activities and outings were suggested and discussed. We saw that people's views were recorded about food, and following discussions at these meetings, items were either added or removed from the menu.

The Chief Executive also used these meetings as an opportunity to ensure that people knew how to make a complaint. People we spoke with confirmed that this was the case, and that they were confident that their concerns would be taken seriously. One person said, "If I had to, I feel confident to make one", and another person said, "If there's anything wrong, I speak to them and they sort it." Records showed that complaints were recorded appropriately and that managers had investigated complaints, including speaking to all people involved, and where necessary had apologised. We noted that the form used to record complaints did not indicate whether the complainant was satisfied with the outcome which is an area for development.

Good

Is the service well-led?

Our findings

We saw that the registered manager was visible around the service, and had a good rapport with people who used the service, who she knew individually. Staff we spoke with were positive about the registered manager's style and said that she was approachable.

The registered manager had a detailed programme of audits in place which were planned across the entire year. These covered areas such as health and safety, catheter care, and personally checking that pressure mattresses were on the correct setting. An audit had been carried out for people who had catheters, including checking that the catheter was not due for replacement, and ensuring that it had been flushed and that catheter needs were on the care plan. We saw some innovative approaches to audit. For example, the registered manager had carried out a 'dining experiences audit'. This confirmed that place settings were put out, that cutlery and crockery were clean and that food was served promptly and hot. The audit also asked 'Are people seated with consideration to promoting conversation?' This showed person-centred leadership, and the results corresponded with our own observations of the dining experience.

The registered manager conducted a bi-monthly medicines quality assurance check, which confirmed that she had seen written evidence of training, including for specialist techniques such as injecting, competency assessments for staff who administered medicines, that medicines were correctly stored and refrigerated, and that weekly audits had been correctly carried out. An audit of moving and handling equipment was also scheduled regularly, and showed that all equipment was correctly checked and serviced. Staff had received a large file of compliments from people who used the service and visitors, many of which praised the registered manager directly. One said, "Anything I need she helps, she helped me overcome my problems."

The registered manager also maintained a system for ensuring that staff had up to date training. This recorded each staff member's training record against mandatory training, and discarded training which was considered to have expired. Separate systems were in place for nursing staff, care workers, office staff and domestic staff.

The provider was meeting its legal requirements to display its certificates of registration with CQC, and was displaying ratings from its previous inspection prominently in the main lobby. At the previous inspection, the service was rated "requires improvement" and several breaches of regulations had been found. The provider had submitted a comprehensive action to address these breaches, and had recruited a new care manager to implement these, who had become the registered manager. We saw that the provider had met and implemented this improvement plan and in many cases had gone beyond what was required in order to ensure high quality care, for example implementing an electronic care notes system which had incurred significant expense but had ensured a robust system for maintaining records of people's care. We saw that the registered manager and Chief Executive were responsive to our feedback about the service, and had begun implementing suggestions from the inspection team.

The Chief Executive had a strong presence in the service, for example greeting everyone that she met and asking after their welfare and speaking positively about individuals that used the service, which showed that

she knew people well. The Chief Executive told us that she had a "hands on" approach to dealing with issues, and told us, "If there is one criticism of me people make it is that I am always on the side of residents." She also told us that she had agreed to the new computer system, but had insisted that the main terminal for staff was in a communal area so that it did not take staff away from people they were supporting. Several people told us that they found the Chief Executive's approach dynamic and motivating.

The Chief Executive also attended all staff meetings alongside the registered manager. Staff meetings took place every month, and were held separately for nurses, care workers and clinical governance staff. Meetings for care workers frequently began with discussions of upcoming religious holidays, with detailed information for staff on the meaning of the holiday and people's requirements, and planned events to mark these occasions. Staff regularly discussed areas such as people's support needs, mealtimes, capacity and consent, risk assessment and infection control. Nursing meetings discussed people's conditions, their preferences with regards to care and activities, ensuring that medicines were disposed of appropriately, and clarified duties for night staff. Staff told us that if they attended meetings on their days off, they were paid for this time. One staff member told us, "It is great working here. I am happy. We have a good team and our managers are always engaged and know what we are doing."