Jewish Care

Lady Sarah Cohen House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 6 and 7 January 2016 and was unannounced. Lady Sarah Cohen House is a nursing home that is registered to provide accommodation nursing and personal care for up to 120 people. The home is run by Jewish Care, a voluntary organisation, and has a dedicated unit for people with a diagnosis of dementia. The home is split into three units on separate floors, and at the time of the inspection there were 107 people living in the home.

The home's registered manager was no longer working at the home. 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. There was an interim general manager in place who advised that they would be applying to be the registered manager of the home. The previous registered manager was due to be deregistered for this service.

Staff did not receive sufficiently regular supervision meetings to support them in their role, and agency staff were not provided with clear recorded induction and

Summary of findings

orientation information before working with people. Improvements were also needed in records kept to ensure that people's changing needs were noted and addressed promptly.

The home was clean and well maintained with a refurbishment programme in place. People's care and nursing needs were met, and they were provided with their medicines safely. Their consent was sought before care was provided, and staff had training in the Mental Capacity Act 2005 and understood their duties when people were unable to consent. Some people expressed concerns over staffing numbers, and particularly the use of significant numbers of different agency staff. The management team were aware of this issue and in the process of further recruitment to posts at the home.

Safe systems were in place for recruiting staff. Staff training needs were assessed, with systems in place to make sure they had training in relevant areas. Staff showed a good knowledge of people's life histories and preferences regarding their care and support needs. They were clear about the procedures for reporting abuse and felt that management listened to their views.

People were provided with a wide choice of food, and were supported to eat when this was needed. They spoke highly of the food provision in the home. They were also very satisfied with the range of activities available to them, organised by the living-well team.

People's health needs were met, and they were supported to consult with health and social care professionals as needed without delay. They had the opportunity to be involved in decisions about their care and how they spent their time at the home. They and their relatives attended meetings or spoke directly to a manager to raise any issues of concern.

The provider had systems for monitoring the quality of the service and engaged with people and their relatives to address any concerns. When people made complaints they were addressed appropriately.

At this inspection there were two breaches of regulations, in relation to staff supervision and monitoring of changes in care recorded. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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. There were assessments in place to minimise identified risks to people, and staff knew the correct procedures to follow if they suspected that abuse had occurred.

Safe recruitment procedures were in place, and the home was in the process of recruiting more staff to fill vacancies.

People received their medicines safely. The home was clean and hygienic.

Is the service effective?

Requires improvement

The service was not always effective. A training programme was in place, but staff did not receive regular supervision sessions and there was no recorded agency staff induction or orientation.

Staff understood people's right to make choices about their care, and the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People received a varied choice of meals and staff supported them to meet their nutritional needs.

People's health care needs were monitored. People were referred to the GP and other health care professionals as required.

Is the service caring?

Good

The service was caring. Staff were caring and knowledgeable about the people they supported, and understood their preferences and life histories.

There were opportunities for consultation with people and their representatives about their care and support.

Is the service responsive?

Requires improvement

The service was not always responsive. Care records were not always sufficiently detailed and precise, to ensure that people's needs were met fully and responsively.

People using the service and their relatives were encouraged to give feedback on the service and use the complaints system.

Care plans were in place outlining people's care and support needs.

Staff were knowledgeable about people's needs, interests and preferences in order to provide a personalised service. A wide range of activities were available for people including occasional trips out of the home.

Summary of findings

Is the service well-led?

The service was well-led. The provider had systems for assessing and monitoring the quality of the service so as to make improvements where appropriate. People found the management team to be approachable and supportive.

Good

Lady Sarah Cohen House

Detailed findings

Background to this inspection

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

At the previous inspection of the home in May 2013 we found that the provider was meeting the regulations inspected. Prior to this inspection we reviewed the information we had about the service. This included information sent to us by the provider such as notifications and safeguarding information.

This inspection took place on 6 and 7 January 2016 and was unannounced. The inspection was carried out by two inspectors, a pharmacist inspector, and two specialist advisors who were nurses with professional experience of working with older people and people with dementia.

At the time of the inspection there were 32 people living on the first floor (primarily for people with advanced dementia), 36 on the second floor, and 39 on the third floor . During the inspection we spoke with 21 people who were living at Lady Sarah Cohen House and 17 visitors or friends who were visiting people there. We looked at the care plans, risk assessments, and daily records relating to 18 people, and medicines administration records for 39 people.

We observed care in communal areas across the home, including medicines administration, mealtimes, and some scheduled activities. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being.

We spoke with five nurses, one student nurse, 11 care workers, a living-well (activities) worker and the living-well manager, the housekeeping manager, the service manager, the interim general manager, interim clinical nurse manager, and three unit managers (one per floor). We looked at twelve staff files for recruitment, training and supervision records, the last month of staff duty rotas, accident and incident records, selected policies and procedures, and records relating to the management of the service.

Following the inspection we spoke with two health and social care professionals, who visited the home regularly.

Good

Is the service safe?

Our findings

People told us that they felt safe living at the home, but if they had any concerns they would speak with staff or their unit manager. Staff we spoke with understood the service's policy regarding how they should respond to safeguarding concerns. They knew who they should report to if they had concerns that somebody was being abused. Staff demonstrated an understanding and awareness of looking for and reporting signs of safeguarding concerns for people living in the home. They had received training in safeguarding adults and we saw evidence that incidents had been reported appropriately. There were clear systems in place to manage people's finances through invoicing by the home and receipts being kept for transactions.

Assessments were in place to ensure that risks to people were identified and addressed, and staff signed to confirm that they had read them. Risks recorded included choking, falls, and behaviour that challenged the home. They were reviewed on a monthly basis or more often if required. We checked a sample of the devices in use such as hoists and found that they were clean, functioning well, and had a current sticker attached indicating their safety for use had been checked.

Most people living at the home and their relatives told us that there were enough staff available to meet people's needs. One person told us, "Staff are there when you need them but not in the way all the time." However the majority of people did express concerns at the high number of agency staff used at the home and three relatives of people living at the home suggested that more staff support was needed at some meal times and in the evenings. One relative told us that sometimes staff would not offer to take people down to activities happening in other parts of the home if they were too busy. Another relative said that staff often looked very stressed, and did not always take time to explain to people why they might need to wait for care. Discussion with the management team indicated that they were aware of these issues and working to reduce the number of agency staff used.

We observed call bells being answered promptly during our visit. The staffing in the home during the inspection matched the rotas, which indicated that there were generally at least eight care staff and two nursing staff on duty for every 40 people living in the home, with some extra one to one support provided when assessed as necessary.

Staff advised that there had previously been three nurses on each floor. An extra care assistant had been put in place to replace one nurse per floor with an extra nurse working across all floors, to assist with recordkeeping. At nights two nurses and four care staff were replaced by one nurse and five care staff when a second nurse was not available. Unit managers told us that they were recruiting to four care assistant vacancies on the second floor, and three care assistant vacancies on the third floor.

People's concerns about agency staff included the number of different new agency staff working in any one week, their lack of familiarity with people's care needs, and the time taken for nurses and other staff to train them. We observed that the management team were monitoring the use of agency staff within the home, particularly an issue on the first and third floors. Management told us that Jewish Care had signed up to an apprenticeship programme, and would be taking on six staff to work at the home from 29 February 2016. The management team advised that they were finding it difficult to recruit sufficient nurses, and were therefore reliant on some agency nurses, however they were actively working to address this situation.

Safe recruitment procedures were in place to ensure staff were suitable to work with people. Staff had undergone the required checks before starting to work at the service. We saw evidence of application forms, interview records, disclosure and barring checks, checks on professional qualifications, three written references and confirmation of each staff member's identity.

Training certificates showed that staff had received training in relevant health and safety topics including moving and handling, food hygiene, infection control, fire awareness, and health and safety.

People did not have any concerns about their medicines. They told us, "The nurse always talks to me about my tablets and asks if I need any extra for my back pain," "I do not have to worry, I get my tablets at the right time," "I get to speak to the nurse and if I need any extra I ask and get what I need." We found that medicines were being managed safely, and that people received their medicines as prescribed. All prescribed medicines were available at the service and were stored securely in a locked medicines trolley within a locked room.

Medicines administration records (MAR) showed that medicines were administered only by registered nurses.

Good

Is the service safe?

Creams were administered by care assistants as they helped people with personal care. This was clearly documented on the MAR chart demonstrating that people received their medicines safely, consistently and as prescribed. We also saw that allergy statuses were always clearly documented for each person.

Medicines fridge temperatures were taken each day; however the staff at the home were advised to seek training on how to do this accurately because the fridge thermometers were not being reset correctly, and the current temperature was not always documented. The ambient room temperature where medicines were stored was recorded each day and found to be within acceptable limits. Controlled drugs (CD) were stored in a locked CD cabinet inside an appropriately secure room. CD balance checks were completed twice a day by two registered nurses. We carried out random checks of several medicines including controlled drugs (CD) and found that the quantity in stock matched the quantity recorded on the MAR chart and in the CD register. Controlled drugs no longer needed were destroyed on site.

MAR charts included a picture of the person to assist staff in identifying the correct person during medicines administration. There were protocols in place for medicines to be used on an 'as and when' basis with clear instructions on when to use the medicines. Running balances were kept for medicines that were not dispensed in the monitored dosage system. Where a variable dose of a medicine was prescribed, nurses recorded the actual number of dose units administered on each occasion.

Where appropriate, medicines were explained to the person receiving them and relatives were informed that they were welcome to join the GP on the ward round if they had any medicines queries. Less than 10 people were being given medicines covertly in accordance with the care home medicine policy. Documentation was in place that had been signed by the next of kin, a nurse, and the person's GP. These covert medicine agreements were reviewed every six months. Nurses received training on the safe handling of medicines during induction. They then received an annual refresher, and a medicines competency check unless there was a reason to repeat it sooner. Care assistants received medicines awareness training from the pharmacy.

All but one of the people we spoke with told us that the home was kept very clean. They noted, "Cleaning staff do a brilliant job, the place is spick and span." During our inspection visit the home was clean and well maintained, with some ongoing redecoration and refurbishment taking place on the first floor. Two housekeeping staff were working on each floor during the day, with a supervisor checking on progress and cleanliness. Cleaning charts were kept showing systems in place to clean all areas regularly, and infection control audits were carried out. We noticed an unpleasant odour in a small number of areas, and brought these to the attention of the unit or service manager. In one case staff had already reported the issue and steps were taken to address it without delay. Staff told us that all cleaning materials were kept locked and secured, with trolleys taken into each room when cleaning.

We observed that parts of the building became very warm at certain times of the day. Two people living at the home told us that sometimes their rooms were too hot, and it was difficult to open a window for ventilation as many of them were sealed. We discussed this issue with the service manager who advised that this was being addressed as part of the home's refurbishment programme, with new sensors put in place to moderate the temperature across different areas in the home.

Requires improvement

Is the service effective?

Our findings

People spoke positively about the staff that support them. They told us, "'Staff are very good and aware of what I need," and "Staff are fantastic and do a wonderful job." A relative told us, "Staff are wonderful, they work so hard, and are called constantly. They never complain or lose their cool."

Staff told us that they felt well supported by the home's management particularly in recent months. However they noted that at times they felt under pressure to meet people's needs as promptly as they wanted, particularly when they were working with agency staff who did not know people's needs. We found that there had been significant gaps in the frequency of staff supervision and appraisal sessions particularly for care staff. There were records of individual nurses' supervision but this varied in frequency from three-monthly to one session in a year. There were few records of individual care staff receiving supervision, with none of the nine care staff whose records we looked at having any individual sessions recorded within the last year. A small number of group supervision sessions were recorded but these did not include all of these staff members. The provider's own policy on supervision indicated that individual sessions should be provided on a two-monthly basis. We were also concerned to find that there was no record of induction or orientation information provided to agency staff who worked at the home.

The evidence above demonstrates a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Management were aware of these issues and working to ensure that nurses provided supervision to care staff. Following the inspection the general manager advised that they had adapted the permanent staff induction protocol to be used for new agency staff. They were also meeting with all agencies used to discuss their expectations for staff and staff awareness of the Jewish way of living.

Regular staff meetings were held at the home, including a daily stand up meeting on each unit which staff said was useful for problem solving. Management advised that they had recently introduced reflective meetings where staff encountered difficulties, but records were not kept of these meetings.

Staff employed by the provider spoke positively about the training they had received particularly the six day corporate induction training when they commenced work. This included training in the Jewish way of life, safeguarding, privacy and dignity, equality and diversity, dementia, and person centred care, and enrolment for the national care certificate. Some staff had also attended Synagogue as part of this induction.

We saw records of training in a wide range of relevant areas including allergy awareness, mental health awareness, visual impairment and sensory loss, and Parkinson's disease. Training monitoring records indicated some areas in which training was behind, including health and safety, mental capacity, dementia, responding to distressed behaviour, and diabetes, but there was a plan in place to provide further training in these areas.

Nurses spoke positively about their training and were supported to undertake relevant professional development courses including training in venepuncture, wound care, catheterisation and front line leadership. A student nurse we spoke with felt very well supported in their role.

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

People can only be deprived of their liberty 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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People said they were able to make choices about their care. There were assessments available regarding their capacity to make decisions and consent to their care and treatment. Staff had received training on the MCA and DoLS. They could explain the process to be followed if they believed that people were not able to consent and make decisions about their care and treatment. DoLS applications had been made for people living at the home

who were unable to go out unsupervised, and did not have capacity to consent to this arrangement. Where there were conditions attached to a safeguard, we found evidence that some of these were being met, for example providing one person with a choice of activities to participate in. However conditions of DoLS were not recorded clearly within people's care plans alongside evidence of how they were met. For example one person's conditions included checking for signs of discomfort, but there was no record of how this was carried out (such as use of a pain chart).

There were also no formats in place for recording decision specific mental capacity assessments and best interest decisions made on behalf of people who did not have capacity to make a decision. We discussed this with the service manager who advised that these formats were being developed.

Staff demonstrated a good understanding of how to seek people's consent. They ensured that people with capacity to do so were supported to make their own decisions and choices, asking their permission to carry out each task. People's consent was recorded for use of their photographs in care records. There was clear documentation in place to record decisions about whether resuscitation should be attempted and advanced wishes for people living at the home, demonstrating the person's wishes and those of their relatives where relevant.

People were overwhelmingly positive about the quality and choice of food served in the home. Comments included, "I am very satisfied," "The food is phenomenal," "If I need help, if there is something to cut up, they do it immediately," and "They offer a lot of fresh fruit every day."

The home provided a kosher diet for people within the home, and at a café in the main concourse on entry to the home, for people and their friends' and relatives' use.

Dining room tables were set attractively with table cloths and flowers, and menus were provided throughout. Menus were varied with choices available at each meal. Breakfast choices included eggs, fruit, three cereals, porridge and toast with a range of condiments. The food looked appetising and well presented including pureed food which had been moulded and textured for people with swallowing difficulties. The service had devoted significant resources to meeting people's food preferences, gaining people's feedback and ensuring meal times were pleasant and unhurried. A number of volunteers assisted with serving food throughout the home, and several relatives assisted their family members. The catering manager advised that food was central to the Jewish way of life, noting, "We try to accommodate everybody," with a short order menu in place.

Staff sat with people they supported to eat, and interacted with them face to face, prompting people pleasantly and in a personal way. Drinks and snacks were offered throughout the day.

People's nutritional needs were assessed and when they had particular preferences regarding their diet these were recorded in their care plan. Staff were aware of the dietary needs of people who had diabetes or who were on particular diets. There was choice of meals beyond the published menu with acknowledgement of cultural needs as well as personal preferences. The service manager advised that pictorial menus were being prepared for the home to assist people in making choices about their meals.

Food and fluid charts were in place for people on a reduced dietary intake, or where concerns about their nutrition were identified, to monitor the amount of food or drink they consumed. Where necessary we saw that people had been referred to the dietician or speech and language therapist if they were having difficulties swallowing. Nutrition and hydration was monitored by monthly weight records, reporting by care assistants, fluid balance charts and food diaries. Appropriate protocols were in place for people who received food directly by tube.

People said that they had access to health care professionals. They were registered with a local GP, except where they had chosen to retain their GP from prior to living at the home. They confirmed that the GP visited the service at least once a week, and they could see a dentist, physiotherapist, optician and chiropodist when needed. The service made arrangements for people to either attend community health care appointments or for specialist support to visit them. A speech and language therapist was employed by the provider, to support people living at the home. She told us that she liaised with other health care professionals including dieticians and occupational therapists in providing support to people.

Staff recognised that people's health care needs could change quickly, and demonstrated awareness of how these could be monitored, reported and effectively acted upon. One person told us, "They always get a GP or doctor in if I

Requires improvement

Is the service effective?

feel ill." We observed that instructions from health care professionals such as a dietitian or speech and language therapist were followed by staff at the home. Clear records were maintained of the outcome of health care professional visits. Health care audits were in place for people in the home including nutrition reviews, pressure ulcer logs and annual health checks. A health and social care professional told us that at busy times it could be difficult locating staff to contribute to reviews of people's needs. We passed this feedback on to the service manager who undertook to look into this issue.

Good

Is the service caring?

Our findings

People felt well cared for, and that they were treated with dignity and respect. People told us, "They make a very good cup of tea," "They listen," and "They always tell me if they need to change anything in my care plan." Relatives of people living at the home told us, "They do their best," "Staff work very hard," "The care is good," "They will always bring the phone to my mother, even helped her to Face-Time me when I was on holiday," and "They have learned some Yiddish which helps people to communicate with them."

We observed staff at all levels to be kind, attentive and friendly when talking with people living at the home. Care staff had a good rapport with people and showed patience and skill at supporting people with behaviour that challenged, and calming situations when people became agitated. They appeared to know people's preferences well, and spoke with them as individuals.

Staff were observed to respect people's need for privacy and dignity, knocking and waiting for a response before entering anyone's room. On one occasion a nurse entered a room to administer medicines when the person was receiving care from other staff. The nurse withdrew explaining that she would return later when it was more appropriate. Staff said they ensured people's privacy and dignity were protected especially when providing personal care. They said they always spoke calmly and listened to the needs of people they were supporting.

One person said, "The staff always have time for you, especially when I have my bath, they never rush," and others noted, "I never worry when I need anything," and, "The staff always have time to talk and listen." We observed that staff offered people individual choices such as a choice of daily newspapers, and different settings for meals. One person told us, "I have my breakfast on my own every day in my room and I am very happy with my routine." Another person told us, "Most of us have been here many years and feel very comfortable." During the course of our visit staff were observed to be interactive with people and there was a pervading sense of good natured exchanges and communication.

Some people were able to be involved in making decisions about their care. Care records included a place for people or their representatives to sign to evidence consultation, and record their opinion, but these had not all been completed. Records were centred on the individual person including their preferences, and some included the person's views or those of their relatives. They included a life history with a clear indication that relatives had been involved when appropriate.

One unit manager told us, "We record the likes and dislikes of each individual resident and get to know them well." Management told us they aimed for future care plans to be more personalised.

Staff demonstrated that they knew people well and had a good understanding of personal histories and preferences. They told us, "People's likes and dislikes are important and they are written down for us," and "I like getting involved with the history of residents, it helps me with looking after them and gives me a chance to talk to them about their past."

The home provided support for people to practice their religion and have their social, cultural and spiritual needs met. Friday night Shabbat services were held each week and all Jewish festivals were celebrated. There was a synagogue attached to the home, which people from the local community attended. A visiting Rabbi offered spiritual support to people and their families, particularly at the end of life. He also provided support and guidance to staff.

People were happy with the home environment. One person told us, "My room has everything I need and I love my own pictures and bits and bobs." We noted that bedrooms had been personalised, and some had photographs on the door to help people find their room easily. Some rooms were in need of redecoration, but there was a refurbishment plan in place to address this. All rooms had en-suite facilities. The communal areas were well decorated and though large were compartmentalised in a way that made the areas more welcoming.

Requires improvement

Is the service responsive?

Our findings

People spoke highly of the care provided to them and responsiveness of staff. They told us, "The staff always listen to what I need," "Staff are all different but they all are very good," and "The care plan is a genuine working document." One person noted, "Sometimes in the evening the medicine can be a bit late but the staff are always very good and apologise."

A nurse carrying out medicines administration commented that, "I get to speak to and interact with every resident during the process and acquire a lot of knowledge that can impact on changes." Staff told us that care plans "take into account the needs of each individual resident," and "We use the care plans to make sure we are all singing from the same song sheet." A care assistant told us, "We always observe the residents and if there is a change report it to a senior or the manager," and "Any signs or changes in walking or eating could be telling me that they are becoming ill."

People living at the home and their relatives advised that permanent staff were good at meeting their needs. However they complained about having too many different agency staff working with them who forgot details such as oral hygiene, hair washing and supporting people to put on their pressure stockings when needed.

Detailed personalised information was included in people's care plans including relevant risk assessments, however these were not always signed by the person or a representative, and we found gaps in monitoring records kept which may have placed people at risk of not having changing needs identified and addressed.

A wide range of areas were covered in care plans including an admission needs profile, mobility and falls, skin integrity and pressure ulcer prevention, food preferences and nutrition, communication, spirituality, and activities of daily living. All care plans were being reviewed on a monthly basis, however the information on reviews was brief, often simply indicating no change to the care plan in that area.

Turning charts were completed for people at risk of pressure ulcers, and food/fluid charts were in place for people at risk of dehydration or poor nutrition. However we found significant gaps in MUST assessments (for calculating nutritional risk), bowel records, bath/shower and oral care records, and falls and Waterlow risk assessments (for pressure ulcer prevention). Gaps included missed entries, a lack of dates, signatures or designation of the staff member completing them, and a failure to total the score indicating the risk of malnutrition or pressure ulcer risk. Recording the month that people were weighed without the actual date meant that is was difficult to track changes in weight accurately. These gaps potentially placed people at risk, for example a person who had moved into the home in the last two months did not have a nutritional risk assessment in place, despite losing weight in their first month living at the home. Their pressure risk assessment was not totalled to calculate the risk.

Daily records indicated the care provided but did not give any account of people's general wellbeing and how they spent their time. There were no records kept of the key-working support provided. Overall we found that the recording systems in the home did not easily join together to give a full picture of people's care needs and progress. For example activity records were being kept by the living-well team in a completely different area of the home to the care files that had very sparse activities recorded in them. Similarly daily records did not clearly demonstrate that all support areas specified in the care plans were being met by staff.

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

There was some evidence of care plans being reviewed to meet people's changing needs, including changes in medicines and moving and handling requirements. One unit manager described a new style of care plans to be implemented that would be more individualised.

People were given a wide range of varied and stimulating choices about how they spent their time. One person told us, "The music is fantastic, not just for residents but staff also, it gets us together."

Another person said, "The activities here are very nice, if I'm ill someone comes to check on me and see if I can go." During our visit we observed care staff chatting with people, offering to take them to activities on other floors of the home, dancing with them, and playing cards. We

Requires improvement

Is the service responsive?

observed some group activities including an interactive puppet show, music group, and a country and town naming exercise with staff and people living at the home involved.

There were schedules of different activities posted in communal areas on each floor of the home. A 'living-well' team of five staff supported by a manager provided group and one to one activities throughout the day, each day of the week except Saturdays, with one link worker per floor of the home. Our observations and records indicated that uptake of group activities was good, and people told us that activities were very popular in the home. Many people were aware of the activities on offer that day, and had planned their day accordingly, for example going down to the synagogue hall to watch a movie in the afternoon.

Other activities recorded for people living at the home included sessions from a specialist dementia activities provider, reminiscence, creative writing, a stroke club, dance and exercise, sensory groups, entertainers, ceramics, art, drama therapy, quizzes, gardening, and one to one use of an Ipad. People were able to book private physiotherapy and hairdressing appointments, and University of the Third Age speakers held sessions at the home. Recent trips out had been arranged to the cinema, Whipsnade zoo, bowling, Alexandra palace, the royal air force museum, the Wigmore Hall and a west London synagogue.

People were aware of the home's complaints procedure and told us that they felt able to complain if they were unhappy about anything. They were also able to raise any concerns at a regular residents and relatives meeting held at the home. We found that there was a clear record in place of all complaints received since the last inspection, including details of action taken to address them. There was information displayed in the home explaining how to make a complaint, and minutes of recent resident and relatives meetings showed that people had an opportunity to raise their individual and group concerns.

We observed one person raising concerns with one of the unit managers, who was friendly and listened patiently and attentively. People told us, "If I had a complaint about how I am treated I could appeal to the nurse," "I have no cause to complain but know the manager," and "I would know who to talk to if I needed to report anything that I did not like."

One relative told us that they had previously complained about wheelchairs not being kept clean enough, and felt that this was better now. They noted, "The manager wants to help." Records showed that complaints were taken seriously, and the service upheld complaints where these were found to be substantiated. However records did not always indicate what changes were made as a result to ensure that there was no repetition of the issues raised and that learning was taken forward. Similarly records of accidents and incidents did not always include learning taken forward. Issues raised in complaints included insufficient staff numbers, and use of too many agency staff. The general manager advised that these issues were being addressed as part of a general review of staffing. He noted that reflective practice sessions were held with staff where areas for improvement were identified, however there were no records of these meetings or the their outcomes.

Good

Is the service well-led?

Our findings

People and their relatives were positive about the home's management. People told us, "The manager always listens," "I can always raise any issues," and "If I have something on my chest I always try to discuss it and get a good response." Relatives spoke highly of the individual unit managers. Others said, "Care is excellent," and "The service is well managed, and "The home is top of the pile – it's brilliant." However, one relative felt that there were not enough staff, so that "excellence is at the cost of the nurses being overworked." Another relative felt that there were not sufficient systems in place to give feedback about the service.

We met with all three unit managers, the interim clinical nurse manager (who had only been in post for two weeks) and the interim general manager who had been in post for three months. We were told that the interim general manager would be applying to the Commission to become the registered manager, and that the previous registered manager who no longer worked in the home was to deregister.

Staff felt that the management supported them and were approachable. One staff member stated, "I always feel as though I am listened to." They told us that there had been recent improvements made in the staff team working together as one home, and supporting each other. They felt well regarded and valued by the provider organisation. They advised that complaints were now dealt with at a more local level, instead of at a provider level, enabling changes to be put in place more efficiently.

Staff said that they were sometimes short of staff but this was addressed when they raised it with the management team. We saw records of quarterly staff meetings at which people's care needs were discussed, alongside teamwork issues, infection control, supervision, records, medicines and communication. There was evidence that issues raised at previous meetings were followed through, for example review of care plans. Staff said they felt able to raise concerns if there was the need. They were aware of the provider's whistle blowing policy and other policies for ensuring the smooth running of the home. There were also occasional meetings for nurses, care staff, and night staff.

The management of the service was open and inclusive. The service produced a regular newsletter about the home for people using the service and their relatives. The last relatives and residents meetings were held in October and March 2015 during which topics discussed included refurbishment plans, new approach CQC methodology, activities, catering and housekeeping. There were also regular meetings of the Friends of Lady Sarah Cohen House committee, who arranged events and fundraising including a Chanukah raffle, annual calendar, and garden fete.

The interim general manager met with other onsite managers from Jewish Care services weekly for a head of department meeting, at which recent topics discussed included hotel services, housekeeping, and activities provision. As a result of one of these meetings an earlier breakfast was arranged for people wishing to have this. There was also a monthly registered managers' forum arranged within Jewish Care which the interim general manager attended, and administrative staff attended a care home administration working group meeting periodically to share good practice.

We saw records of a large number of comprehensive internal audits relating to the service. A recent financial and administrative compliance audit awarded the service 95 per cent in compliance, with the only area for improvement being that two staff signatures should be on every petty cash voucher.

Staff from the pharmacy conducted six-monthly medicines audits, and we were told that there was a plan in place for senior nurses to conduct monthly audits of a random sample of medicines charts. In November 2015 a dementia environment survey was undertaken for the home with actions put in place including reviewing the hearing loop system, and replacing a specified grab rail.

We saw evidence of care plan audits taking place on each unit, with notes shared amongst staff about how the records should be updated in each folder. Unit managers also explained that there was a new auditing and recording system being put in place that required monthly updates to be personalised and more easy to follow.

An infection control audit was undertaken in December 2015, with prompt action taken to address shortfalls. A staff training audit from September 2015 identified mandatory training needs that had not been met, with plans in place to address them. The integrated quality in care homes

Good

Is the service well-led?

team from the local authority had also been providing support to the home, including a recent visit in December 2015 where improvement to storage of medicines was identified and put in place.

A survey of all stakeholders in the home in 2014 scored the home at 77.6 per cent, following which improvements were put in place regarding food provision, staff time with people, access to senior staff and privacy. A survey of relatives' views in 2015, with 42 people responding, indicated that 68 per cent found it easy to speak with a senior staff member, but 100 per cent thought their relatives were treated with dignity and respect and felt safe.

An unannounced management night visit was carried out in October 2015, with some disciplinary action taken as a result of concerns found. The management were working towards a service action plan dated 14 December 2015, including priorities to improve care plan reviews, further auditing, protecting staff time around meals, medicines and personal care, staff supervision and training, and unit managers presence out and about on their units.

We saw records of current gas safety and electrical installation certificates, portable appliances testing, water testing, lift and hoist servicing, fire equipment servicing and regular fire drills and call point testing. A refurbishment programme was in place at the time of our inspection, with eight rooms at a time blocked for refurbishment on the first floor. The week after the inspection a specialist dementia day care centre run by the provider was moving into the ground floor of the service, and it was hoped that some people living at the home would be able to access this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff employed by the service provider did not receive sufficiently regular supervision and appraisal, and agency staff did not receive sufficient induction and orientation to carry out their role effectively.Regulation 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and monitoring records were not sufficiently detailed and precise, in order to ensure that people's needs were fully and responsively met. Regulation 12(1)(2)(a)(b)(c)