North London Bikur Cholim Limited

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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

About the service:
• North London Bikur Cholim Limited is a domiciliary care agency. It provides personal care to people in the Jewish Orthodox community living in their own houses and flats in the community. It provides a service to younger and older adults, people with physical disabilities, sensory impairments, mental health needs, learning disabilities or dementia.
• The provider has one domiciliary care agency within their registration.
• The service's office is based in Stamford Hill, and personal care is provided to people in surrounding areas.
• At the time of the inspection it was providing a service to 22 people.

People's experience of using this service:
• People were protected against avoidable harm, abuse, neglect and discrimination. The care they received was very safe.
• People's risks were assessed and strategies put in place to mitigate the risks.
• People's likes, preferences and dislikes were assessed and care packages met people's desired expectations.
• Relatives provided consistently positive feedback about the care, staff and management. They said the service was caring, timely, effective and well-led.
• People's care was person-centred. The care was designed to ensure people's independence was encouraged and maintained.
• People and their relatives were involved in the care planning and review of their care.
• The service had a stable management structure. The provider had implemented systems to ensure they continuously measured the safety of people's care and quality of the service.
• The service met the characteristics for a rating of "good" in all the key questions we inspected. Therefore, our overall rating for the service after this inspection was "good".
• More information is in our full report.

Rating at last inspection:
• Good (report published 6 September 2016)

Why we inspected:
• This was a planned inspection based on the rating at the last inspection.

Follow up:
• We will continue to monitor the service through the information we receive.
• We made a recommendation in our inspection report, which we will follow up at our next 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? The service was safe Details are in our Safe findings below.	Good
Is the service effective? The service was effective. Details are in our Effective findings below.	Good
Is the service caring? The service was caring. Details are in our Caring findings below.	Good
Is the service responsive? The service was responsive. Details are in our Responsive findings below.	Good
Is the service well-led? The service was well-led. Details are in our Well-led findings below.	Good

North London Bikur Cholim Limited

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:
• Our inspection was completed by one inspector 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. Our expert by experience had knowledge about personal care of adults within the community.

Service and service type:
• North London Bikur Cholim Limited is a domiciliary care agency. It provides personal care to people in the Jewish Orthodox community living in their own houses and flats in the community. At the time of the inspection it was providing a service to 22 people.
• The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
• Our inspection was announced.
• The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.
• Our inspection process commenced on 8 January 2019 and concluded on 8 January 2019. It included visiting the service's office and telephoning people who used the service and their relatives. We visited the office location on 8 January 2019 to see the registered manager and office staff, and to review care records and policies and procedures. We telephoned eight relatives on 8 January 2019.

What we did:

• Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public and the local authority. We checked records held by Companies House.

• We asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

• We spoke with eight relatives of people who used the service. We were unable to speak with people themselves.

• We spoke with the registered manager, the deputy manager, compliance consultant and three care workers.

• We reviewed four people's care records, three staff personnel files, staff training documents other records about the management of the service.

• We requested additional evidence to be sent to us after our inspection. This was received and the information was used as part of our inspection.

Good

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

• Relatives told us they felt the service was safe. One relative said, "Yes, [relative] feels safe." Another relative told us, "When the carers are here, [relative] feels happy and safe."

Systems and processes
• People were protected from the risks of harm, abuse and discrimination.
• There was a safeguarding and whistleblowing policy in place which set out the types of abuse, how to raise referrals to local authorities and the expectations of staff.
• Staff and management we spoke with had a good understanding of their responsibilities. One member of staff said, "I would call the manager and talk to her. If she did nothing I would call the [local authority]. If violence I can call the police straight away." Another staff member said, "First thing I would contact [registered manager] and tell her about it. I let her make the decision. The next stage would report to the police and CQC."
• Staff completed safeguarding training to provide them with knowledge of abuse and neglect.
• The registered manager told us there had been no safeguarding incidents since the last inspection.

Assessing risk, safety monitoring and management
• The service aimed to obtain as much information about a person before a new care package commenced. Before admission to the service a 'referral and initial assessment form' was undertaken to assess whether the service could meet the person's needs. This included assessments from commissioning bodies, and feedback from people and their relatives. One relative told us, "When we first started, we had our own assessment with the agency and with the [occupational therapy] team. To approve everything, we all worked together and there was a discussion."
• People's care files included risk assessments which had been conducted in relation to their support needs. Risk assessments covered areas such as the home environment, mobility, personal care, medicines, smoking, alcohol and substance misuse, falls, equipment, and manual handling.
• The care documentation set out the risks and control measures in place to mitigate the risks. For example, one person's risks were related to behaviours that challenged. The care records stated, "[Person] can become resistive and can scream and cry with people he is not familiar with. Carer should try and calm him down and district his attention with a toy or something he likes to eat [for example] crisps."

Recruitment and staffing levels:
• Through our discussions with the registered manager, staff and relatives of the people who used the service, we found there were enough staff to meet the needs of people who used the service.
• Staffing levels were determined by the number of people using the service and their needs, and could be adjusted accordingly. Relatives told us timekeeping was good and their relatives were not rushed when receiving care. One relative said, "You can't always control lateness, but it's not a problem here."

• Staff told us they had enough time between visits to be punctual and their shifts were covered when they were on sick and annual leave. One staff member told us, "If I am sick I call the day before and they provide another carer. I know they do cause when I come back I asked who covered me." Another staff member said, "Every time I am sick I get someone in my place."
• The provider followed safe recruitment practices.
• Staff recruitment records showed relevant checks had been completed before staff worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records.

Using medicines safely:
• The registered manager and staff told us none of the people who used the service required support with medicines. Records showed relatives supported people with medicines if they needed help.
• The compliance consultant told us the service could support people with medicines if they required.
• The service had a medicines policy in place which covered the recording and administration of medicines. It stated that staff had to undertake training before they were able to administer medicines.
• Records showed staff were up to date with medicines training.

Preventing and controlling infection:
• Staff completed training in infection prevention and control on a regular basis. Records confirmed this.
• Staff had access to personal protective equipment such as gloves, aprons and shoe covers. They also had access to alcohol-based hand rub for disinfecting their hands. One staff member told us, "You get gloves, mask, alcohol rub, and apron. I pick up from the office." Another staff member said, "I have gloves and hand rub."
• Staff were required to complete training in food hygiene, so that they could safely make and serve meals and clean up after preparation. Records confirmed this.

Learning lessons when things go wrong:
• There were no recorded accidents or incidents since our last inspection.
• There were appropriate forms and processes in place for use for recording and investigating accidents and incidents. There were systems in place to learn when things went wrong. For example, the service had received a complaint about a person receiving a call visit earlier than requested. The service had increased the number of spot checks of people to ensure people were getting their call visits at the right time. Records confirmed spot checks had increased and the service had not received any more complaints about call visits for people.
• Staff members were aware to call the office to report any issues if there was an accident or incident.

Good

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

People's outcomes were consistently good, and people's feedback confirmed this.

• One relative said, " I know that this is an extremely difficult job. [Staff are] very kind and they try." Another relative told us, "[Staff] ask how you are and smile. That's how it should be. They do what they're supposed to do." A third relative commented, "This agency is able to fulfil our needs."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Assessments of people's needs we saw were comprehensive, expected outcomes were identified, and care and support regularly reviewed.
• Staff applied learning effectively in line with best practice, which led to good outcomes for people and supported a good quality of life.
• People's preferences, likes and dislikes were recorded. Information included meal choices, personal hygiene routines and other documentation related to the person's home environment.

Staff skills, knowledge and experience:
• When new staff joined the service, they completed an induction programme which included shadowing more experienced staff. The induction covered topics such as the role of the care worker, confidentiality, person-centred approach, policies and procedures, communication, record keeping, moving and handling, emergency first aid, infection control, fire safety, health and safety, safeguarding, whistleblowing, and medicines. One staff member said, "I had induction."
• The service provided was specific to the Jewish Orthodox community. The induction programme included a topic on values and cultural awareness, and understanding of the orthodox way of life.
• Training was provided in subjects including autism awareness, basic life support, care planning, challenging behaviour, communication, cultural awareness, dementia care, dignity and respect, person-centred care, diversity and human rights, duty of care, emergency aid awareness, food hygiene, health and safety, incontinence awareness, learning disability awareness, lone working, manual handling, medicines, The Mental Capacity Act 2005 (MCA), mental health for older people, palliative care, positive behavioural support, privacy and dignity, preventing pressure ulcers, infection control, and record keeping. Records confirmed this.
• Staff told us the training provided helped them to perform their role. One staff member said, "So many trainings. It is classroom training. [The office] send me an email when there is training. They call as well to confirm." Another staff member told us, "I get constant training. Manual handling, health and safety, and hygiene."
• Staff felt supported and received supervision. One staff said, " We go through how my experiences are with [people]. How I am getting along. Am I happy with the work and is the [person] happy." Another staff member told us, "They ask me what is happening, how is the [person] and how I am working with them. If I am happy."

Supporting people to eat and drink enough with choice in a balanced diet:
• People were supported to eat and drink enough.
• Some people required support with their meals. Care records showed how people's dietary needs were assessed, such as their food preferences and how they should be assisted with their meals. For example, one care plan stated, "[Person] prefers [vegetarian] meals. Carer to sit during meal time and encourage [person] to eat."
• Relatives told us their relatives were supported with food when needed.
• Staff spoken with during our inspection confirmed they had received training in food hygiene and were aware of safe food handling practices when supporting people in their homes.

Staff providing consistent, effective, timely care within and across organisations:
• The service worked with other agencies and professionals to ensure people received effective care.
• Where people required support from other professionals this was supported and staff followed guidance provided by such professionals. Information was shared with other agencies if people needed to access other services such as GPs, health services, social services, meal services, and Jewish Orthodox services.

Supporting people to live healthier lives, access healthcare services and support:
• Where necessary, the service supported people and relatives with healthcare appointments and reviews.
• Staff were aware of what action to take if people were unwell or had an accident. They told us they would contact people's GP or phone for an ambulance as necessary and inform people's next of kin. One staff member told us, "When they have an appointment they ask if I will go with them. Just for the company. If unwell would talk to the family. Once I called the ambulance."
• Relatives told us staff help with health appointments when needed.
• Records showed the service worked with other agencies to promote people's health such as district nurses, GPs, pharmacists and a palliative care nurses.

Ensuring consent to care and treatment in line with law and guidance:
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.

• Staff ensured that people were involved in decisions about their care, and understood the procedures to make sure decisions were taken in people's best interests. One staff member told us, "Always ask consent. I tell [people] what I am going to do, if they say no I don't force them." Another staff member said, "First, I would try gently explain to the [person] why they need a bath and have a conversation and see why they don't want. If they don't want I report to the office."
• Initial assessments made by the referring authority showed that capacity assessments had been completed.
• We spoke to staff and found they had a good understanding of the principles of the MCA and confirmed they had attended MCA training.
• However, we found that the provider's practice was not in keeping with the legal principles and requirements of the MCA.
• Records showed people signed to consent however we saw that if a person was unable to sign documents, the provider had asked a relative to sign on behalf of the person when there was no evidence that the relative had a Lasting Power of Attorney (LPA). LPA accords the person who is given power of attorney the power to make decisions about your daily routine (washing, dressing, eating), medical care, and life-sustaining medical treatment. It can only be used if you're unable to make your own decisions.

• We spoke to the registered manager who told us they would follow up with people's relatives if their relative had a LPA in place. This meant appropriate consent was not always sought where people lacked the capacity to make an informed decision, or give consent in accordance with Mental Capacity Act 2005 and associated code of practice.

We recommend that the service consider current guidance on the Mental Capacity Act 2005 (MCA) and take action to update their practice accordingly.

Good

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported:
• Relatives told us that staff were kind, courteous and sensitive. One relative said, "[Staff are] all extremely nice and helpful and always available." Another relative told us, "All amazing. [Staff are] trying their best." A third relative commented, "[Staff are] kind, gentle and bathe [relative] nicely."
• Staff showed a good awareness of people's individual needs and preferences. Staff talked about people in a caring and respectful way. One staff member said, " [People] are nice to me. They are good families. They ask me if I want a coffee." Another staff member told us, "You got to enjoy your job. I do enjoy it. The care work is very rewarding. Feels like you have done something [with] love and passion."
• Staff told us that the people they supported had been with them for long periods of time so they knew them well. One staff member said, "I have three [people]. One of them for about one year and six months [and] I have another for six months." Another staff member told us, "I enjoy what I do. I have been with [people] for years and some of them are quite attached to [me] and it's quite rewarding. Sometimes you can't describe the feeling when you see someone happy. I get to be in a special bond with them."

Supporting people to express their views and be involved in making decisions about their care:
• People were supported to express their views and to be involved, as far as possible, in making decisions about the care and support they received.
• Records showed people who used the service and relatives were involved in care planning and reviews. One relative said, "[Staff] always listen to me. They know our needs which can be difficult at times."
• Staff told us they supported people to make decisions about their care and knew when people needed help and support from their relatives. One staff member told us, "I will get information from [the office] and go to the family." Another staff member said, "[Registered manager] calls me and asks if I want a new job. I meet with [registered manager] and talk about the [person] and then send me to them and the family to see if we can work together."
• The provider had their own voluntary advocacy service they could refer people to if they wished. The provider had charitable status and therefore they had been able to fund additional hours for people to receive care and support that fully met their needs.
• People and their relatives were involved in making choices about their care. One staff member told us, "I give them an option. I give the freedom and the choice."

Respecting and promoting people's privacy, dignity and independence:
• Relatives told us their privacy and dignity were respected. The service provided care for Jewish Orthodox people in the community. One relative said, "From what I can see Jewish Orthodox needs are respected." Another relative told us, "[Staff] go out of their way for our Orthodox needs. They know of our fast days, when to go to the synagogue and they light candles." Staff understood and respected people's Jewish

Orthodox needs. One staff member said, "I ask and check everything about them. You wash hands. You don't mix meat with their meal. I try to do the way they like. I got training at [Jewish Orthodox organisation]."
• Staff we spoke with gave examples about how they respected people's privacy. One staff member told us, "I shut the door and close curtains with personal care. Dignity of the [person] is very important to me. I seek the interest of the [person] first." Another staff member said, "I close the window and door [when giving personal care]. When I take their clothes off I cover their private area."
• The service promoted people to live as independently as possible. Staff gave us examples about how they involved people doing certain aspects of their own personal care and day to day activities which supported them to maintain their independence.
• Promoting independence was reflected in people's care plans. One care plan stated, "[Person] will put the toothbrush in his mouth but will not actually brush his teeth. [Staff member] to encourage and help him with brushing his teeth."

Good

Is the service responsive?

Our findings

Responsive – this means that services met people's needs

People's needs were met through good organisation and delivery.

Personalised care:
• All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.
• The care documentation clearly showed that the service identified and record communication impairments. Care records explained what communication aids, such as glasses and hearing aids, people required as part of their daily lives. For example, one care plan stated, "[Person] has a hearing impairment. [Person] has hearing aids. Carer to ensure they are turned on. [Person] has reading glasses."
• Staff showed us they knew people's likes, dislikes and preferences. They used this detail to care for people in the way they wanted. For example, care plans had clear details around how a person preferred to be supported with personal care and day to day tasks necessary to obtain desired outcomes. One care plan stated, "[Person] enjoys soft playing areas and loves to watch DVDs in his time especially [specific television show]."
• Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "We would have no problem [with LGBT people]. It is our job to provide care. We would do an initial assessment and take it from there. They would express their needs and [we] try to accommodate them." A staff member said, "[LGBT people] [have] to be respected. I treat them equally."
• Training records showed staff had completed diversity and human rights training.

Improving care quality in response to complaints or concerns:
• There was an appropriate complaints management system in place.
• Staff knew how to provide feedback to the management team about their experiences which included supervision sessions and team meetings.
• Relatives were aware of how to make a complaint. One relative said, "A very long time ago I complained as my mother fell down. The carers were changed."
• Records showed the service had received one formal complaint since the last inspection. We found the complaint was investigated appropriately and the service had provided a resolution to the complaint in a timely manner.

End of life care and support:
• The registered manager told us one person was receiving end of life care at the time of our inspection. Records showed this person had an end of life care plan on how they wished to be supported.
• People were supported to make decisions about their preferences and staff supported people and relatives in developing end of life care plans. Other healthcare professionals such as GPs, community and palliative

care nurses were involved as appropriate.
• Staff gave us examples how they supported people with end of life care. One staff member said, "It's very sad. I have a [person] now and one [previously] [end of life]. After he passed away I looked after his father. It was very sad. The family still call me and talk to me."
• The service had an end of life policy which was appropriate for people who used the service.
• Training records showed staff were up to date on end of life training.

Good

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility:
• Relatives told us how they felt the service was well run and responsive to their concerns and needs. One relative told us, "I'm happy with this agency. Happy is an understatement. I couldn't do without them." Another relative said, "[Registered manager] is a lovely lady. I love the little extras that she does. The extra mile. During [Jewish Orthodox festival], little packages are given to friends and one was brought to my [relative]. They all go out of their way. They have a good system set up and we're never left in the lurch". A third relative commented, "There is nothing to improve on. [Registered manager] is just amazing."
• Effective communication systems were in place to ensure that staff were kept up to date with any changes to people's care and support systems to staff. For example, staff meetings were held on regular basis. One staff member said, "We have meetings every one to two months. They ask if everyone is happy and what is happening with the [people]." Another staff member told us, "We talk about the job and the [people]. How to behave and be better. It is good."
• The service had a policy and an understanding of their responsibility of duty of candour. Duty of candour is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• Staff spoke positively about registered manager and working for the service. One staff member said, "Worked for company for a year and half. It is very good. They are very nice. They help people and help me. They look after people very well. They don't make you stress. They give you a nice way to work for the people. [Registered manager] is very good. She is nice. She tries to help us and [people who used the service]. Try to make the best for them." Another staff member told us, "Worked here for eight years. I like the job because I am so happy when I see people and help somebody. It is a nice job. [Registered manager] is very nice." A third staff member commented, "I have been very happy with North London Bikur Cholim on how they treat the [people and the [staff]."
• The registered manager had worked for the agency for a long period of time and had a clear understanding of her role and the organisation. The registered manager told us, "I've been the registered manager for about 20 years. Been with the agency longer than that. I am hardworking, caring, devoted and looking for good for everyone. We are not a business because we are [charity]."

Engaging and involving people using the service, the public and staff.
• The registered manager and the staff team knew people and their relatives well which enabled positive relationships to develop and good outcomes for people using the service. One relative told us, "I can call the office and I can share. They understand me. I never feel alone to make decisions. They help me and have a terrific listening ear. A very nice support. To have them care for my [relative] is a privilege and [Registered manager] is one super woman." Another relative said, "[Registered manager] more than a manager. Whenever you need her, she's there. She is ready to hear from us at any time."
• The quality of the service was also monitored through the use of annual surveys to get the views of people who used the service and their relatives. The last annual survey was conducted in January 2018. Overall the results were positive.
• The service conducted regular spot checks which included visiting people in their home and telephone calls. Records confirmed this. The spot checks topics included punctuality, personal appearance of care staff, respect for service users, ability to carry out care, knowledge and skills, and health and safety. One staff member said, "[Office staff] call the family to see if they want to complain."
• Relatives told us staff were observed by the office staff in their homes to see how they were performing.

Continuous learning and improving care:
• There was a quality assurance programme in place. The provider employed an external compliance consultant to oversee the programme.
• The service was in the process of setting a business continuity plan. The compliance consultant told us, "We are process setting up a continual improvement plan. To get a track of what is going on. What people hope to achieve, what the service users want to achieve and any changes."

Working in partnership with others:
• The service worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the registered manager told us the service had worked with local Jewish Orthodox organisations, the local authority, learning disabilities adult and children's team, health professionals, Jewish meal delivery services and ambulance service.
• The registered manager told us people and their children were holocaust survivors who used the service. The service worked in partnership with a Jewish refugee's association to enhance life for those survivors.