Parcs Healthcare Limited

Gokul Nivas

Inspection report

4 Windsor Avenue
Leicester
LE4 5DT
12-14 Windsor Avenue
Tel: 0116 266 1378
Website:

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced which meant the manager and staff did not know we were coming.

Gokul Nivas provides accommodation, care and support for 10 people whose first language is Gujarati. There was a registered manager in post at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The registered manager for Gokul Nivas did not work in the home and spent limited time there. The day to day running of the home was the responsibility of the care manager.

Providers are required by law to inform the CQC of incidents in the home that could affect the health, safety

Summary of findings

and welfare of the people who use the service however despite identifying incidents which met this criterion during our inspection, we could not be confident that these had been reported, as required.

The Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) were not being respected by staff which meant people's human rights had not been recognised.

The staff we spoke with, including the care manager had limited understanding of their role in protecting and respecting people's rights and their own responsibility to work within the law.

Most of the people we spoke with said they were happy with the care they received but some people were reluctant to raise concerns about their care with the staff or manager.

We observed some positive interactions between staff and the people who used the service however we also saw some interactions which did not provide people with the support they required or maintain their dignity.

There were limited arrangements in place to measure the quality or effectiveness of the care that was provided.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not consistently safe.

No safeguarding notifications had been received from the provider although during our inspection we identified incidents which should have been reported.

Staff were not following the Mental Capacity Act 2005 for people who lacked the capacity to make decisions. The provider had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards for two people, even though their liberty may have been restricted.

The provider had appropriate recruitment processes in place to ensure the staff it employed were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The care manager told us the training information we looked at had not been kept up to date. We saw that staff had not received recent training in topics such as care of people living with dementia or managing behaviours that challenge.

People were offered choices about the food and drink they were given and received support from staff whenever necessary to enjoy a positive mealtime experience.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed the care people received was inconsistent. People we spoke with who were able to be independent were satisfied with their care but some of the people who needed more support told us they were unhappy about the care they received.

We saw care being provided with kindness and observed people being supported in a dignified manner which respected their privacy. We also saw some negative interactions where a person became distressed but did not receive any emotional support or empathy from a senior member of staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Summary of findings

Some people who used the service told us they were worried about making complaints because they were concerned about the effect it might have on their care. Questionnaires were used to gain feedback from the people who used the service and their families but these were written in a language and format which most of the people living in the home could not speak or understand.

People living in the home were supported to maintain their cultural identity and religious beliefs.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were no systems in place to monitor the quality of the service provided, identify incident trends or share information from investigations to reduce the risks to the people who used the service.

There was a limited audit process in place but this had not identified errors on the Medication Administration Records (MAR) charts we saw during our inspection.

The provider had not informed us, as required, of incidents which adversely affected people or safeguarding concerns.

Gokul Nivas

Detailed findings

Background to this inspection

We visited the service on 09 July 2014. The inspection team consisted of two inspectors and a translator.

At the time of our inspection there were 10 people living in the home. With support from the translator, we spoke with six people who used the service, three staff, three visitors, the registered manager and the care manager. We observed care and support in the communal living room and looked at the care records for five people.

We used and recorded the Short Observational Framework for Inspection (SOFI) during the lunchtime period. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Before our inspection we reviewed the information we held about the home and contacted the local authority for the service, to obtain their views.

The provider had been asked to complete a document called the provider information return (PIR) by 20 June 2014; however we had not received this prior to our inspection. The PIR provides background information on the service information on the service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

The care manager told us there was a process in place for reporting safeguarding concerns and we saw the policy had been discussed at a recent staff meeting however we had not received any safeguarding notifications from the service.

We spoke with one person via the interpreter, this person alleged they had been mistreated by staff and we saw their comments had been recorded by staff in their care record. However there was no indication that the allegations had been investigated by the service or referred as a safeguarding concern to the local authority. We spoke to the registered manager and care manager about the allegations and they told us the allegations were 'just examples of the person's behaviour' that challenged. There was no record that this person had been referred for a specialist assessment of their mental health to determine if this was correct. This meant the provider had not responded appropriately to an allegation of abuse.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people who used the service were unable to make decisions about their care, support and safety. The Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements, where people lack capacity, to ensure appropriate decisions are made in their best interests.

We saw in a person's care record that they had been unsettled and had used the fire exit to leave the property without being observed by staff. This person was living with dementia and did not have the capacity to understand they could be placing themselves at risk of harm. Staff brought the person back into the home and arrangements were put in place to lock the exit to prevent the person using this door again. No risk assessment had been completed following the incident and there was no recorded contingency plan in place to ensure people who used the service would be able to leave the building promptly should an emergency, for example, a fire, occur.

Another person sometimes presented with behaviour that challenged. There were several entries in this person's care record relating to them being distressed and raising their voice at other people and staff. Staff told us and it was documented in their care record that they were sometimes taken back to their bedroom and put back in bed during these incidents and left there until they had 'calmed down'. This person used a wheelchair and was unable to mobilise independently.

The manager had not recognised that they were depriving these people of their liberty or that the actions they were taking were unlawful.

These are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's health risks had been assessed however some of the information provided by the assessments was not used to plan how care should be delivered. We saw that some people had been assessed to be at high risk of developing pressure ulcers however despite increased risk, there were no management plans in place to change the way they were cared for to protect the condition of their skin.

There were two members of staff and the care manager working in the home on the day of our inspection although when we arrived the care manager was in the adjoining home. The manager told us they could increase staffing at short notice by calling for assistance from the adjoining home however this arrangement worked both ways and meant at times there was a reduced number of staff available at Gokul Nivas.

In line with cultural tradition, each person who used the service was bathed on a daily basis. However this meant that, at times, both carers were unable to attend to other people. People we spoke with told us the staff were sometimes slow responding to call bells depending on the time of day. A relative told us their family member had fallen when, because their call for assistance had not been responded to in a timely manner, they had tried to go to the bathroom unaided. This meant that, at times, the level of staffing did not reflect the needs of the people who used the service.

We looked at three staff files and saw that appropriate pre-employment checks had been completed prior to staff starting work in the home. The checks included application forms detailing previous employment, appropriate references and satisfactory disclosure and barring checks to ensure the person was of good character. This meant that an effective recruitment process was in place to keep people safe and prevent unsuitable people from working with vulnerable people.

Inadequate

Is the service safe?

There were regular checks on the home environment, including monitoring of water temperatures, equipment maintenance and health and safety hazards. There were personal evacuation plans in place to use in an emergency, such as a fire. This meant the provider had arrangements in place to ensure the environment remained safe for the people who used the service, their visitors and staff.

Requires Improvement

Is the service effective?

Our findings

The training records we looked at were not up to date but indicated that a significant number of the staff working in the home had not received recent training, other than manual handling. Training for staff in managing behaviour that challenged, mental capacity, DoLS, safeguarding of vulnerable adults, dementia and nutrition had not been completed. Staff we spoke with told us they had received medication training but there were no arrangements in place to monitor the competencies of staff to ensure they continued to follow safe practices.

This meant the staff were not given an opportunity to access training to improve the care they provided. The registered manager told us it was difficult to source training that was appropriate for people whose first language was not English.

This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw from the care records that people were referred to healthcare professionals to support their health and well-being however we noted that recommendations were not always implemented. One person had been seen by both the GP and district nurses who had recommended their legs should be elevated to help reduce swelling. During our inspection we observed this person sitting in a chair with their feet on the floor. The registered manager and care manager told us the person sometimes refused to comply with the recommendations they had received but this was not recorded in their care record. The person who used the service told us, "If I sit in the recliner chair or if I have a stool I put my feet up". This meant the person was not being fully supported to comply with the recommendations.

We observed at lunchtime that two people experienced some difficulty with swallowing causing them to cough when eating and drinking. Staff had reported their concerns about the people's risk of choking to the GP and people had been referred for swallowing assessments. There were entries in the care records reminding staff to puree food or cut it into small pieces and we saw staff implementing this at lunchtime which meant the provider had recognised the risk and taken interim actions whilst they waited for specialist advice.

The first language of the people living in the home was Gujarati. People were supported to maintain their cultural identity and religious beliefs by staff who could communicate fully with them. Some of the people who used the service were living with dementia. There was information about dementia and the affect it could have on people displayed on a notice board for staff to read. We did not see however that the environment had been adapted to assist people with understanding the layout of the home or people provided with pictorial information which could have been more meaningful for people living with dementia.

People who used the service were provided with a choice of vegetarian food in line with their preference and beliefs. People we spoke with told us they were happy with the food and we observed drinks were offered regularly throughout the day. One person said, "We can choose our food and have drinks whenever we want". Another person said, "I like the food we get. I ask for cold milk as I don't like warm and they always bring it". This meant the staff recognised the importance of offering sufficient food and fluids to maintain people's wellbeing.

Staff we spoke with told us they felt supported in their roles and received regular supervision and appraisal from their manager. Staff files we looked at contained records of supervision sessions and we saw topics discussed included checks of the member of staff's wellbeing or personal issues which might affect their work. It was also an opportunity for the manager to discuss any shortfalls with the member of staff's performance. This meant staff supervision was an opportunity for staff to discuss their worries or concerns and receive managerial feedback on the quality of the care they provided.

Requires Improvement

Is the service caring?

Our findings

We spoke to the people who used the service about their experiences of care. One person said, “Staff take good care of me”. Another person told us, “The staff treat me well”. Some of the people who relied on staff for support them told us they were not so happy. One person said, “It’s not good but it’s ok”. Another person told us, “It’s alright but I also feel it’s not right”, but did not feel able to explain why this was.

During our inspection we observed mostly positive interactions between staff and the people who used the service. We saw staff treating people with dignity and supporting their rights to privacy by using screens when transferring people from their wheelchairs into armchairs using a hoist. We found that the language used by staff was appropriate, supportive and polite however we also saw some less appropriate interactions where people did not receive a supportive response from staff. For example we saw one person who became distressed but the senior member of staff present did not offer reassurance or support which meant the person’s emotional needs were not met. We also saw that some of the care record entries made by staff were not written in a professional manner which supported and promoted people’s dignity.

Some of the people using the service were living with dementia and we used our SOFI tool to help us see what people’s experiences were like. By using SOFI we were able to observe how people spent their time and whether they had positive experiences. We spent 30 minutes looking at people’s experience during lunch. Only two of the people who used the service sat together to eat lunch. The remaining people stayed in their armchairs and ate their lunch from individual tables. The registered manager told us that people preferred this; however we did not see this choice had been documented in people’s care records. We observed two people being supported to eat. Staff spoke with people whilst they were eating and encouraged them to participate by placing food directly in their hands. This meant people were encouraged to eat in a way that suited their needs. We also saw one person drop their cup and the contents spill over their clothing, meal and table. A person who used the service alerted staff and the table was wiped but there was no attempt to change the person’s clothing, dry their legs or check their meal was still edible which meant this person’s comfort and dignity had not been considered.

Requires Improvement

Is the service responsive?

Our findings

The provider had a complaints procedure in place and relatives we spoke with told us they would raise concerns or grumbles directly with the staff. Some people who used the service told us they did not feel comfortable raising concerns directly with the manager or staff and would ask their relatives to do so on their behalf. One person said, "I live here so what can I say? I mention things to my family but they don't always speak to the manager". Another person said, "I can't say anything. They'll say I've said lies to you". This meant although there was a procedure in place the provider had not ensured that people felt confident to use it.

People were provided with a questionnaire to feedback their views about living in the home and their satisfaction with the service they received. We saw the questionnaires were written in English which many of the people who used the service did not speak or understand. The questionnaires had been completed on people's behalf by the care manager and each one had the same responses recorded. The care manager told us they sat with people, asked them the questions and completed the form for them. This meant people were not given the opportunity to raise concerns anonymously, nor were they supported by an independent person or advocate. Therefore the outcome of the surveys could not be relied on for impartiality.

The registered manager told us the service was in the process of issuing 'This is Me' booklets for people and their families to complete. This booklet, provided by the Alzheimer's Society, is used to gain information about people who are living with dementia so that their care can be centred on their likes, dislikes and interests. The booklet is available in several languages including Gujarati however the returned copy we saw was printed in English which the people who used the service did not understand. This meant people had not been supported to access information in a language or format they understood.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the care records for five people who used the service. The records we looked at provided basic information about people and their care needs. There was some information provided about people's individual likes, dislikes or preferences. Staff we spoke with knew the people who lived in the home well and were able to tell us how they liked their care to be provided. People we spoke with told us they could choose when they went to bed and what time they wanted to get up in the morning. One person said, "They (the staff) ask if I want to get up. If I say I want to sleep for a while then they leave me". Another person told us, "I get up and go to bed whenever I want". This meant people were supported to have control over their lives.

Relatives were encouraged to visit whenever they wanted but were asked to avoid mealtimes and visiting later in the evening when the home would be secured for the night. Relatives we spoke with understood and supported the reasons for the restrictions, particularly regarding the security of the home, although we could not see that the mealtime restriction had been discussed and agreed with the people who used the service. One relative said, "Some of the people get a bit messy when they eat. It's more dignified for them if visitors aren't here".

During our inspection we saw people taking part in Bhajans, a type of Hindu devotional prayer. The activity planner indicated that people were given the opportunity to practice yoga and take part in card games. People we spoke with told us they would have liked more to do during the day. One person said, "We do nothing during the day, just sit here and look at everyone". A relative said, "I don't know what they do during the day but we always try and bring some activity with us for (their relative) to do. They used to really enjoy gardening and I'm sure, if there was the opportunity they could help with that here". This meant people had not been offered opportunities to take part in hobbies or interests of their choice.

We saw that some people were supported by their families to attend their chosen place of worship. People without family or friend support were provided with minibus transport however, as the bus was shared with other homes, access to attend a religious service was dependent on the availability of the minibus which meant, for some people, access could be limited.

Requires Improvement

Is the service well-led?

Our findings

The registered manager for the service lived a distance away from the home and told us he only spent one day a week there. The day to day running of the home was the responsibility of the care manager. The care manager provided a weekly update to the registered manager which meant they were kept informed about the management of the home. The registered manager told us they intended to change the management arrangements in the near future to provide a registered manager on site.

The provider did not have systems in place to monitor the quality and safety of the services they provided. There was a process in place for auditing medication administration records (MAR) charts however, during our inspection we identified minor discrepancies in the way staff were recording the reason why medication had not, on some occasions, been administered. The audit process, undertaken by the care manager had not identified these errors, which meant the audits had been ineffective.

There was an incident reporting process in place however we saw this was not used consistently by staff as some falls had not been recorded. There were no arrangements in place to review or investigate incidents and accidents which could identify trends such as an increase in falls when staff numbers were lower than usual.

These issues are a breach of Regulation 10 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

There were occasional meetings arranged for people who used the service and we saw from the minutes that the main topic discussed was people's satisfaction with the food. More recently people had been asked about their preferences for the outdoor paint colour.

Relatives were regularly invited to meet with staff to discuss the running of the home and we saw a meeting had been arranged for shortly after our inspection. A satisfaction survey for relatives had been distributed recently but at the time of our inspection only one response had been received. The response did not raise any concerns with the service.

Staff meetings took place every three months. From the minutes we saw the meetings were used to update staff on policies, emergency evacuation arrangements and any changes in the home which might affect the way care was delivered. The staff meetings were also used to remind staff about offering choices to the people who used the service including what clothes they would like to wear.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to monitor the quality of the provision.** **The registered person did not identify, assess and manage risks relating to the health, safety and welfare of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person did not make suitable arrangements to ensure that service users were safeguarded against the risk of abuse by not responding appropriately to any allegation of abuse.** **The registered person did not have suitable arrangements in place to protect people from unlawful control.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People were not always treated with consideration and respect.** **The registered manager did not assist people to express their views.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of others.**
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure persons employed received appropriate training.**