Diwali Ltd

Diwali Nivas

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

The inspection took place on 3 August 2016.

Diwali Nivas is registered to provide care and support for Asian elders who may experience a mental health condition or be living with dementia. Diwali Nivas is registered to provide care for up to 21 people. At the time of our inspection there were 21 people living at the home, however one person was in hospital.

A registered manager was in post. The registered manager was also the provider, and they were supported by a registered manager 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.

At the last two inspections of the service in June 2014 and April 2015 we asked the provider to take action. We asked the provider to make improvements in the arrangements for cleanliness and infection control. We received an action plan from the provider which outlined the action they were going to take which advised us of their plan to be compliant by November 2015. We found that the provider had taken the appropriate action. Medicines were ordered and stored safely, and staff were trained to administer the medicines people required. Staff sought medical advice and support from health care professionals.

Personal evacuation plans (PEEP's) were available and stored securely along with other documents and were placed near the fire board and main exit from the home. Copies of the PEEP's were also kept in each person's file and reviewed regularly along with other personal file documents.

People felt their privacy and dignity was respected and staff were kind and caring when delivering care and their choice of lifestyle. Relatives we spoke with were complimentary about the staff and the care offered to their relations. People's care and support needs had been assessed and people were involved in the development of their care plans, and when able were involved in the review of their care plan. When appropriate people were happy for their relatives to be involved in care planning and review. We observed staff offered people everyday choices and respected their decisions. Staff had access to people's care plans and received regular updates about people's care needs. Care plans included changes to people's care and treatment, and people attended routine health checks.

People were provided with a choice of meals that met their cultural and dietary preferences. The catering and care staff were provided with up to date information about people's allergies and dietary needs. People's opinions were sought to meet their individual meal choices. There were sufficient person centred activities provided on a regular basis and people's cultural and religious needs were met. Staff had a good understanding of people's care needs, and people were able to maintain contact with family and friends as visitors were welcome without undue restrictions.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the home. They received induction and on-going training for their specific job role, and were able to explain how they kept people safe from abuse. Staff were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse. Staff were employed in sufficient numbers to meet people's personal care needs and we saw staff worked together to meet people's needs.

Staff told us they had access to information about people's care and support needs and what was important to them. Staff knew they could make comments or raise concerns with the management team about the way the service was run and knew these would be acted on.

The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours. The provider undertook quality monitoring in the home supported by the registered manager. The provider had developed opportunities for people to express their views about the service which included the views and opinions from people using the service, their relatives and health and social care professionals. We received positive feedback from a visiting health professional and contracting staff from the local authority with regard to the care and services offered to people. Staff were aware of the reporting procedure for faults and repairs and had access to the maintenance to manage any emergency repairs. A series of checks had been introduced that were overseen by the registered manager and then checked by the provider.

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.

Shortfalls in infection control that we noted at the last inspection have been resolved.

Potential risks to people were managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported. Staff understood their responsibility to report any observed or suspected abuse. Staff were employed in numbers to protect people and medicines were ordered and stored safely.

Is the service effective?

Good

The service was effective.

Staff had completed essential training to meet people's needs safely and to an appropriate standard. Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005 and asked for people's consent to care before it was provided. People received appropriate food choices that provided a well-balanced diet and met their nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and treated people individually, recognising their privacy and dignity at all times. People were encouraged to make choices and were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs. People and their families were involved in planning how they were cared for and supported. Staff understood people's preferences, likes

and dislikes and how they wanted to spend their time. People told us they would have no hesitation in raising concerns or making a formal complaint if or when necessary.

Is the service well-led?

Good

The service was well led.

The provider used audits to check people were being provided with good care and to make sure records were in place to demonstrate this. People using the service, their relatives and visiting professionals had opportunities to share their views on the service.

Diwali Nivas

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.

The inspection visit took place on 3 August 2016 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. The expert was fluent in Asian languages and had experience of working with elderly people from an Asian culture. This inspection was unannounced.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about Diwali Nivas. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home. We spoke with commissioning staff from the local authority who told us they had undertaken a quality monitoring visit, and found the provider was operating effectively.

The provider is required to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This inspection was a follow up visit to check improvements had been made following a previous inspection visit, so the provider did not have an opportunity to complete this.

During this inspection, we asked the provider and care home manager to supply us with information that showed how they managed the service, and the improvements regarding management checks and governance of the home following our previous visit. We also asked the provider to forward more information following our visit, as some documents were not available on the day.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported. We used and expert by experience who could speak a variety of Asian languages so we could be sure we understood fully the experiences of people in the home. We also used the short observational

framework tool (SOFI) to help assess whether people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

To gain people's experiences of living at Diwali Nivas we spoke with seven people and two relatives. We also spoke with the provider who is also the registered manager, the registered manager, three care staff, a maintenance person and the cook. We also spoke with a visiting healthcare professional.

We looked at four people's care records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs, risk assessments and care plans. We also looked at quality audits, records of complaints, incidents and accidents at the home and health and safety records.

Good

Is the service safe?

Our findings

At our inspection of 5 June 2014 and 28 April 2015 we found that there were unsafe arrangements in place for cleanliness and infection control. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of Regulation 8 of the Health and Social Care Act 2008.

The provider sent us an action plan outlining how they would be compliant by 16 November 2015.

At this inspection we found that improvements had been made. We found that since the refurbishment of the home, areas that were in need of improvement had been upgraded. We saw that there had been changes to shower rooms and flooring in the home. The shower rooms had been re-decorated and the doors had been improved to protect them from water damage. The cleaning materials and equipment were now stored inside the home in an appropriately locked room. A cleaning schedule was in place, which informed staff what areas were to be cleaned and the materials that were to be used. The policy and procedure included details on how spillages should be cleaned and included how often cleaning equipment should be sterilised.

People told us they felt the home was clean. One person said, "Yes (the home is) cleaned very well."

People told us they felt safe. A relative told us they felt their relation was safe. A relative said, "My mum is hoisted, (when I have been here) that is with two staff." Another relative said, "[Named] is very frail so when she tries to move from her bed an alarm goes off, and someone attends within seconds. We don't have any concerns about her safety."

The provider had taken steps to ensure people were protected from abuse. There was a safeguarding policy and procedure that informed staff of the action to take if they suspected people may have been abused or were at risk of abuse. Staff we spoke with had received training in safeguarding people from harm. They had a good understanding of what abuse was and their responsibilities to act on any concerns they had about people's safety. Staff knew the different types of abuse and how to identify them. Staff were aware of the whistle blowing policy and told us how they could use it if their concerns were not acted on. They also knew which authorities to report any on-going concerns to if required. The provider and care home manager were aware of their responsibilities and ensured safeguarding situations were investigated and reported to us appropriately.

The provider had taken measures to minimise the impact of unexpected events. Fire safety equipment was regularly tested and practice fire drills were undertaken regularly. Each person had their own personal evacuation plans (PEEP's) so staff and the emergency services would know what support people needed in the event of an emergency. The provider had a business continuity plan should the staff require to deal with an equipment breakdown. This had been reviewed and ensured staff would know who to contact in an emergency and people would continue to receive a continuity of care.

When asked about staffing numbers, one person said, "There are enough staff, they are very nice people." And another said. "I used to feel there were not enough staff, but I don't feel that anymore."

Staff were able to tell us about individual people's support needs to enable them to stay safe. People's care records informed the staff and included risk assessments, which covered areas related to people's health, safety, care and welfare. Care plans and associated risk assessments were reviewed regularly to identify any changes in risks to people's health and wellbeing. The care plans provided clear guidance to staff in respect of mitigating risk. For example, guidance on food allergies and what equipment should be used to mitigate moving and handling risk. People and their relatives told us they were involved in discussions and decisions about how risks were managed. That meant the staff group were well informed and helped people stay safe by involving them and when appropriate their relatives in care plan and risk assessment reviews.

Staff told us they believed there was sufficient staff on duty to ensure people were safe. They said there was an allocated member of staff present in communal rooms to ensure people were safe. A care worker told us, "Yes we feel there are enough staff." People confirmed staffing levels were sufficient to keep them safe, and were aware who to report concerns to.

The provider told us he used a staffing calculator to ascertain the numbers of staff required to care for people. We also looked at the staff meeting minutes, where staff had raised the issue of where they felt there were staff shortages at certain times of the day. The minutes confirmed the staffing numbers had been an increased which ensured safe care could be provided.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for three staff. We found that the relevant background checks had been completed before staff commenced work at the service.

We looked at the medication administration records (MARs) for five people. Medicines were stored securely and the temperature of the room and medicines fridge was regularly monitored. Records showed that the temperature was within the appropriate limits for the purpose of storing medicines safely. The provider had processes in place to ensure the continued safe storage of medicines if temperatures exceeded the recommended maximum'. Staff we spoke with knew the safe range of storage temperatures for both the medicine room and medicine fridge.

The MAR's had people's photographs in place to reduce the risks of medicines being given to the wrong person, and included staff's initials to confirm each medicine had been given. They also included information about identified allergies and people's preference on how their medicine was to be offered.

One person said to us, "Normally I manage my own medicines, but if there is a need they help me." Another person said, "They give me medicine and wait till I have taken it." A visiting relative said, "I don't have any concerns with the home as they deal with [named] medical problems, they are even happy to take [named] to hospital appointments."

For people in receipt of 'as required' or PRN medicines, we found that protocols were in place to ensure staff had instructions on the circumstances they were to be given and maximum dose in any 24hour period. There were separate charts to record where staff had to apply topical creams. These charts were detailed and included where the cream should be applied which ensured staff would apply these consistently and in the correct place.

Good

Is the service effective?

Our findings

People said they were happy with the staff that supported them and felt staff understood their needs and how they liked to be cared for. One person said, "They are good, we have fun together." People told us they felt the staff group were trained to provide the support they required.

Staff were provided with training that allowed them to provide effective care for people. Staff said there was enough training and they did not feel they had any gaps in their knowledge. There was evidence staff had received induction training when their employment commenced. This was followed by further training in safeguarding, dementia, moving and handling, food and hygiene, fire awareness, health and safety and mental health awareness. Staff then received regular annual training updates to ensure they could provide effective care consistently.

Our observations confirmed that staff put their training into practice. Staff used a wheelchair correctly whilst they kept the person informed as to what they were about to do, guided them and provided reassurance throughout the process.

Staff felt communication and support amongst the staff team was good. There were daily handover meetings which provided staff with information about people's health and wellbeing. Staff also told us they felt supported through regular staff meetings and supervision meetings with the registered manager. Staff supervision was used to advance staffs' knowledge, training and development by regular meetings between the management and staff group.

The provider and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 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 are called the Deprivation of Liberty Safeguards.

A relative said to us, "I have power of attorney (for my mother), The provider always contacts me first about any concerns or decisions (that need making)." We found evidence of mental capacity assessments for individuals and best interest assessments. Where people were unable to make decisions themselves, the correct procedure had been followed to protect their rights under the Act. There was a form in place for assessing people's mental capacity. We found that the provider had ensured that people were protected by the DoLS. Records showed that they had been granted four DoLS and applied for a further five. That ensured the necessary authorisation was either in place or applied for, and any deprivation on people's liberty had been identified.

Throughout our visit we saw that staff offered people choices and sought consent before they supported

them. One relative said, "We were involved about our choices for the colour of mum's bedroom. They did paint it in the colour mum asked for."

People told us they had sufficient amount to eat and drink. Staff provided a choice of culturally appropriate Asian meals, refreshments and snacks. When asked about the food, one person said, "I have enough food, I don't need to ask for extra." Another said, "One day I didn't like what was cooked, they made me something else." They added, "I often feel hungry, they provide me with fruit or milk."

A relative told us, "It's very nice here, there is no problem with the food." The cook had detailed information about people's dietary needs, food tolerances and preferences. When spoken with care staff were also aware of people's food allergies. The menu showed that a variety of vegetarian meals were offered, which were a nutritionally balanced and suited people's cultural and religious needs. Hot meal choices were available for lunch and tea. We observed staff assisting people who required assistance to eat their meal. This was relaxed and done at a pace to suit the person, and staff were positioned to enable good eye contact.

Staff offered people mid-morning snacks which included cut up fruit or a yogurt. A variety of hot and cold drinks were available. We saw from people's care records that an assessment of their nutritional needs and plan of care was completed which took account of their dietary needs. Where required people's weight was recorded and staff knew where to access help for those who required further support. Staff recorded people's weights and used a colour coded system to highlight where people had lost weight they were referred to their GP, speech and language therapist (SALT) or dietician.

People told us they able to maintain their health and had access to health care support as and when required. People's care records also confirmed that they received health care support from a range of health care professionals, which included doctors, specialist nurses, optician and outpatient appointments at the hospital. There was evidence where people's additional health needs had been responded to by staff as they arose.

Visiting healthcare staff provided a service for people with wound care and other nursing needs. We spoke with a visiting healthcare professional who was complimentary about the staff. They said the staff were well organised and usually had the person ready for any treatment to take place.
Four people had an advance plan of care (DNAR) in place where people had made an advance decision about their care with regards to emergency treatment and resuscitation. People could be confident that staff would act in accordance with their wishes.

Good

Is the service caring?

Our findings

People told us they felt the staff were caring, and used familiar terms such as Ma, Uncle and Auntie, are culturally accepted and preferred by people in the home. One person said, "I was alone at home, I came in for a week to give it a try, and I have been here 8 years now, I like it here." Another person said, "[Named] mentioned that the girls (staff) are lovely and caring." And another said, "They are lovely people, they care for me."

Some people were unable to express their views and opinions so it was difficult to ascertain if they were involved in their care decisions. Some care records were not signed by the individuals but a visiting relative confirmed they were involved when care decisions needed to be made.

Care plans were reflective of people's needs and were reviewed regularly. The provider said care plans were not rigidly reviewed on a monthly basis, but rather when there was a change to the person's needs. They added that relatives were involved when agreed with the person and plans updated with people's health and wellbeing changes.

People told us that staff checked that they were comfortable throughout the day. Individual choices, preferences and the decisions made about their care and support needs were recorded. The daily records about the care and support people received showed that staff respected people's decisions about how they were supported and their lifestyle choices.

Staff respected people's dignity and they understood people's need for privacy. We saw where staff explained discreetly to a person they required personal care, and assisted them to do so. We observed a member of care staff who assisted another person to the toilet ensuring the door was closed. We then saw the same member of staff return and knock on the door and wait for an answer before entering the toilet and assisting the person back into the lounge. The member of staff ensured the person's clothes were re-arranged before assisting them back to the lounge. That demonstrated staff were aware how to assist people whilst recognising their dignity. Staff told us they had read people's care records which contained information about what was important to them.

All bedrooms had a lockable door and most had en-suite facilities that contributed to maintaining people's privacy. Shared rooms had privacy curtains so that people who wished to share could do so without compromising their privacy and dignity. People told us their rooms were comfortable and personalised to reflect their individual tastes and interests.

One relative told us, "We have a good relationship (with staff), (I have) no issues." Another relative told us they believed their family member was well cared for by staff. They said, "[Person] is always clean, they (staff) seem very organised, and they do communicate if there is a problem."

Staff understood the importance of caring for people and they described to us the qualities staff had at Diwali Nivas. Staff said there was a good team who knew people's needs and they all helped each other.

Staff said they enjoyed working at the home and got on well with each other and the people they supported.

Good

Is the service responsive?

Our findings

We spoke with seven people about the planning process for their care. One person said they knew about their care plan but had not signed it, two others were not aware they had a care plan. The remaining people were aware of their plan but were not sure if a relative had seen or signed the document.

People were involved with the review of their care plans when able. Family members were invited to be involved in the review process when the person did not have capacity. One person said, "Before I moved here [staff] came to see me at home. She (the registered manager) spent an hour and a half with me, I wasn't keen to leave my home, but then decided to give it a try and I like it here." The person confirmed the visit included capturing information that formed the basis for their current care plan.

Staff had access to people's plans of care and received updated information on a daily basis about the changes to people's care needs through staff handover meetings. The care plans that we viewed were comprehensive, and showed regular reviews, suggesting the care process was being well managed and the service responded well to people's needs. .

We looked at four care plans which were well detailed. Pre-admission assessments were included and care planning was linked to people's needs and ensured care plans were individualised. There was evidence of up to date photographs, and information on people's past life history, allergies, likes, dislikes, wishes and aspirations. These were incorporated into the care planning to support care delivery in a way people preferred. Staff were able to explain and demonstrated through the care we observed the support that people required.

Three people had advance decision care plans in place and a do not attempt resuscitation (DNAR) advance decision. These had been agreed with the people at the time when they had full capacity. That meant staff were clear about the person's wishes, and could inform any other appropriate authority of this. For example if the person was admitted to hospital.

We spoke with people about what activities were offered in the home. One person said to us, "If I ask them to massage oil into my head they'll do it straight away." Another person said, "They take me to my (outpatient) appointments."

People told us that they liked to sit in one of the lounges that had religious programmes on the television. We saw this was the case with people actively engaging with and speaking about the programmes with us. Another person told us they had been taken by staff to a local temple. The festival they attended extended over nine days and staff assisted the person to and from the festival each day. Others have the option of attending the temple on a daily basis. Other activities offered include exercise classes, games and painting, and regular visits from a person that does hand massages.

People told us they were able to visit their relatives at times suitable to them, and was unrestricted. One visiting relative said they visited at meal times and that enabled them to help feed their relation.

The provider had systems in place to record complaints. People and their family visitors that we spoke with said they knew how to make a complaint. One person said, "If I need anything I speak to the lady in the office." Another said, "I would speak with [the provider]." And another said, "If I need anything I speak with the lady in the office." A visiting relative said, "Overall I am very happy about everything. I can talk to anyone without any hesitation."

Records showed the service had received seven written complaints in the last 12 months. Outcomes had been provided for each, and changes were made to the service, as a result of the outcomes. Analysis by the provider did not reveal any patterns or themes. The information was fed back to staff though staff meetings or individual supervision sessions, so that staff were aware of the issues and any changes that were required.

People and their relatives were invited to regular meetings to plan changes to the menus. People could make suggestions and changes to the running of the home and the meals on offer. There were minutes available for these meetings which people who were unable to attend were kept informed of any changes. People told us they were aware who to complain to if they needed to, and felt comfortable to do so. One person said when asked if they were aware how to make a complaint, "They look after me."

Good

Is the service well-led?

Our findings

Relatives we spoke with were happy with the quality of care their family members received. They told us they had good relationships with the provider, registered manager and with the staff in the home. One relative told us, "They (staff) always smile and greet us, they always respect us." A visiting relative said, "[Named] religious needs are met here very well."

The provider had appointed a registered manager who was in day to day control when the provider was unavailable. They understood their responsibilities in terms of ensuring that we were notified of events that affected the people, staff and building. The provider had a clear understanding of what they wanted to achieve for the service and they were supported by the staff group. There was a clear management structure in the home and staff were aware who they could contact out of hours when necessary.

We saw systems in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced. Staff were aware of the process for reporting faults and repairs, and the 'business continuity plan' was available in the office if there was an interruption in the provision of service. This file included instructions where gas, electricity and water isolation points were located and emergency contact numbers if any appliances required repair. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained. There was an in house maintenance person who undertook repairs and maintained the register when an item was repaired.

People living in the home and their relatives told us they regularly saw the provider visiting the home. One person said, "We see [named] he comes in most days."
We discussed the checks and audits the provider which are undertaken regularly in order to ensure people received the appropriate support and care. The provider told us there were regular audits undertaken by the staff in order to ensure health and safety in the home was maintained. We saw records of the checks that had been undertaken to ensure the building was safe for people. These included checks on the medicines system, care plans, accidents and incidents and people's weight loss or gain and people's nutritional and dietary requirements. This meant the governance in the home was adequate and assured people were cared for safely.

Staff were aware of their accountability and responsibilities to care for and protect people and knew how to access managerial support when required.
We saw evidence that people who used the service, their relatives and visiting professionals were asked to contribute to the quality assurance process. They were sent questionnaires, so were enabled to comment about the quality of service offered by the home. Staff confirmed people at the home participated in the process and if necessary staff assisted them in completing questionnaires. We saw people who lived at the home and their relatives were also invited to meetings with the provider and staff, with minutes being available to us. The outcome from these quality assurance systems resulted in changes to the activities and menus in the home.

A visiting relative said, "We are always invited to meetings (the person clarified these were care plan and relatives meetings), If I can't attend [named relative] does."
The provider understood their responsibilities in terms of ensuring that we were notified of events that affected the people, staff and building. The provider had a clear understanding of what they wanted to achieve for the service and they were supported by the registered manager and staff group. There was a clear management structure in the home and staff were aware who they could contact out of hours were that necessary.

All staff had detailed job descriptions and regular staff and supervision meetings which was used to support staff to maintain and improve their performance. Staff understood their roles and this information ensured that staff were provided with the same information which was used to provide a consistent level of safe care throughout the home. Staff told us they could make comments or raise concerns with the management team about the way the service was run. Overall this suggested the service was well led.