Abbey Care Centre Limited

Bhakti Shyama Care Centre

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

We carried out an unannounced comprehensive inspection of this service on 21 and 24 April 2015. Some breaches of legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to safeguarding, staffing, medicines, premises and equipment, consent and person-centred care.

We undertook this comprehensive inspection to check that they had followed their plan and to confirm that they now met the legal requirements in relation to the breaches found.

There was a registered manager at the service. 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.

Bhakti Shyama Care Centre is a care home with nursing for up to 22 people, specifically designed to meet the needs of elderly people from the Asian Community. There were 20 people living at the service at the time of our inspection.

At our previous inspection we found that there were not always enough staff at the service to meet people's needs, the provider did not follow safeguarding procedures, infection control practices were not always adhered to, covert medicines were not administered in line with accepted guidelines, the provider was not adhering to the principles of the Mental Capacity Act 2005 and care plans did not always reflect people's current needs.

At this inspection, we found that improvements had been made in all of these areas.

The Care Quality Commission had received statutory notifications from the provider where allegations had been made and the local authority had been made aware of these concerns.

People using the service and their relatives did not raise any concerns about staffing levels within the home. The provider was using a formal tool to calculate staffing levels based on people's dependency needs.

The concerns that we found at the previous inspection regarding overflowing bins and some rooms not being maintained to a good standard had been addressed.

Although no one was receiving their medicines covertly at the time of the inspection, the provider had introduced new records which were used to record when people were to be administered medicines covertly. We saw examples where someone needed to be given their medicines covertly and lacked the capacity to make a decision about this, best interests meetings had taken place.

The provider had introduced a mental capacity assessment form and care records included assessments of people's capacity to make decisions. Records for people assessed as not having capacity to make certain decisions about their care and support included best interests meetings. Applications had been made to the local authority when people were subject to restrictions to their freedom.

Care plans were clearly laid out and reviewed regularly. Where recommendations had been made, we found that staff followed these and maintained accurate records.

People told us they felt safe living at the home and we found that where concerns had been raised, the provider had investigated and acted upon recommendations made.

People we spoke with said that staff treated them well and were caring. They told us their healthcare needs were met by staff. Staff demonstrated a caring attitude towards people, during mealtimes and when assisting them around the home.

Care workers told us they were happy with the quality of the training they received. An accurate training matrix was maintained which allowed the provider to plan and book training that was expiring. Care workers told us they felt supported and the registered manager was approachable.

The provider carried out regular audits on medicines, wound care and infection control. A quality assurance manager visited the home regularly which helped to ensure standards were maintained and improvements made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

Medicines were not always stored safely during administration.

The provider was aware of the correct safeguarding procedures to follow when concerns were raised.

There were enough staff to meet people's needs.

The provider followed accepted infection control guidance.

People who were at risk had appropriate plans in place to manage the risk.

Is the service effective?

Good

The service was effective.

People who were not able to understand decisions related to their care had their rights protected. If they needed to be deprived of their liberty, these restrictions were lawful and in their best interests.

Staff told us they felt supported and received regular training.

The kitchen was clean and culturally appropriate food was prepared for people.

People had their healthcare needs met by the provider.

Is the service caring?

Good

The service was caring.

People told us that staff were friendly and treated them well.

Staff respected people's right to choose how they wanted to be supported.

Is the service responsive?

Good

The service was responsive.

Care plans were well laid out and reflected people's current needs. If people had on-going support needs, accurate records were maintained.

Culturally appropriate activities were available to people.

The provider responded to complaints in a timely manner.

Is the service well-led?

Good

The service was well-led.

Staff told us they felt supported.

The registered manager was a visible presence in the service.

Regular quality assurance checks took place and action taken to improve the service.

Bhakti Shyama Care Centre

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 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.

We undertook this unannounced comprehensive inspection on 6 October 2016.

This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection on 21 and 24 April 2015 had been made and to carry out a full comprehensive inspection.

The inspection was carried out by one inspector, a specialist advisor and an expert by experience. The specialist advisor was a registered nurse. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During our inspection we spoke with five people using the service, two relatives and nine staff members, including the registered manager, care quality manager, activities coordinator, administrator and the chef. We looked at three care plans and four staff files. We contacted seven health and social care professionals prior to our visit and heard back from two of them.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection which took place on 21 and 24 April 2015, we found processes to investigate allegations of abuse were not operated effectively, there were not always enough staff to meet people's needs, medicines were not being managed safely and standards of hygiene were not maintained for the premises.

At this inspection we found that improvements had been made.

People using the service and their relatives did not raise any concerns about safety when we spoke with them. The contact details for the safeguarding team were on display in the main office and staff were aware of who they could speak with if they had concerns about people's welfare. A care worker told us, "Safeguarding is about protecting people. If there are any concerns I have to report it to the duty nurse or [the registered manger]." One person told us "I feel safe here, the staff are experienced and seem to know what they are doing."

The provider had effective systems in place to respond to safeguarding concerns which helped to ensure people's safety. The Care Quality Commission had received statutory notifications from the provider where safeguarding allegations had been made and the local authority had been made aware of these concerns. We received confirmation from the local authority of the number of safeguarding referrals received which tallied with the notifications that we were sent. We saw evidence that investigations had taken place and families had been kept up to date.

The registered manager told us they were using a dependency rating tool to assist in determining appropriate staffing levels based on the needs of people using the service. She showed us a working document that was being used to monitor people's dependency levels over time. If this went above a certain level, extra staff were called in to assist the existing staff to ensure that people's needs were met.

On the day of the inspection there was one nurse and six care workers, an increase of one care worker from the previous inspection. The registered manager and activities coordinator were supernumerary and made themselves available to assist with people's care when required.

People had their call bells within easy reach. During the inspection, we observed staff responding to call bells promptly.

People and their relatives did not raise any concerns about staffing levels. One care worker told us that "There are sufficient staff on duty and they help each other on the other floors when required." Another said, "We manage it well. People have their own routine and we work around it." The registered manager told us that "We very seldom use agency care workers, we sometimes use agency staff nurses to cover leave, but on the whole we try and use our own staff."

A new cleaner had been recruited and they were seen attending to each of the rooms throughout the

inspection, ensuring they were clean and presentable. One person told us, "My bed is changed daily and my clothes are washed daily and returned to me, they don't store dirty clothes in the room." The provider had achieved a rating of five for its food hygiene rating following an inspection from the food standards agency on 29 June 2016.

The frequency of clinical waste collections had been reviewed to ensure that bins did not overflow, they were not overfilled and the storage door was locked at the time of our inspection.

The registered manager said there was no one receiving their medicines covertly at the time of our inspection. However, she showed us some covert medicines multi-disciplinary care plans which were in place in case someone needed to be given their medicines covertly. Records showed that for one person the decision to administer medicines covertly was discussed and reviewed by the person's named nurse, GP, the pharmacist, the person's relative and the person themselves. This person lacked capacity and there was a capacity assessment in place and also records of best interests meetings.

On person told us, "I receive my medicine on time every time. And when I require pain killers, the staff bring them to me almost immediately."

The staff nurse told us that they had undergone medicines management training this year and completed a competency test. The training log showed that all the staff had completed comprehensive medicines training and there was competency training planned. There was a medicines administration policy which was accessible to all staff.

The staff told us, "When medicines are ordered they come at least five days to one week early and this gives us the chance to ensure that the medicines are available on the day the person is due."

Medicine was supplied by a local pharmacy in blister packs in four weekly cycles and were colour-coded according to their administration times. Medicines for each person were supplied in a sealed plastic container with the names of the medicine written on top of the container. The medicine for each medicine round was contained in one container instead of individual blisters. The staff nurse told us, "This is excellent because it allows you to check all medicine against the [medicines administration record] and it also saves time." Each medicine chart had the person's photograph and also a picture of the medicine prescribed, there was also a photograph of the person on the blister pack. This helped staff to check the right person was receiving the correct medicines.

During the medicine round we observed the staff checking the medicine against the medicines administration record (MAR) before handing the medicine to the person. They ensured that the person had taken the medicine before signing the MAR. There were no gaps on the recording sheets.

Medicines were stored securely and the keys kept on the person in charge at all times. Controlled drugs were administered and signed by two staff. The register showed that they were checked daily. Medicines were kept refrigerated when this was required. The fridge temperature and the room temperature were checked daily and recorded. There were no gaps in the recording. There were medicines audits carried out independently by the pharmacy annually. Staff conducted audits monthly. Both had not identified any issues. The audits were circulated to the staff.

During a medicine round we observed the staff nurse lock the medicines trolley before going to take medicine to a person, but they left some medicine on top of the trolley unattended. There was a risk that these medicines could have been picked up by a person using the service. We recommend that the provider

reviews systems for ensuring staff competency in safe medicines management.

The care records showed that risks to individual needs of people were regularly assessed and managed. For example, people's care records showed specific actions to be taken by staff in order to prevent the development of pressure sores. In one care plan it was noted that the person should be supported to be turned and repositioned every three hours. Staff had documented their actions on the repositioning sheet to confirm this. In another care plan the staff had recorded the actions they had taken in the treatment of a pressure sore. The progress of the wound could be seen by the photograph. One staff member told us, "We get a lot of advice and help from the tissue viability nurse." The person with the sore told us, "The staff have helped to make it better."

Nutritional risk assessments were also completed to identify any risk of malnutrition. The Malnutrition Universal Screening Tool (MUST) was used to monitor risks and nutritional care plans were reviewed monthly by the named nurse and dietitians were involved in the care of people with potential risks.

Falls risk assessments were completed and reviewed monthly. There were care plans in place to minimise the risk of falls and appropriate steps taken, for example bed rails, the use of which were covered by appropriate risk assessments. Where bed rails and bumpers were used for people at risk of falls, appropriate authorisation was sought.

People with wound management needs had risk assessments and care plans which were reviewed monthly. The Waterlow assessment tool was in use for wound assessment. Body maps and photographs were taken to monitor the wound's progress. The GP reviewed wounds weekly and where necessary the tissue viability nurse was involved. People at risk of developing pressure ulcers and those with wounds were provided with air-mattresses and were turned regularly. There were repositioning charts in place which were completed appropriately by staff.

Staff recruitment checks were thorough. Staff talked us through their recruitment process, telling us they had completed an application form, provided two references and submitted their documents. They told us they had interviews and completed a three day induction. Staff files were completed with evidence of checks carried out before the person was employed. These included evidence of identity, offer letters, references, interview questions and medical questionnaires. All files had a current Disclosure and Barring Service (DBS) check. The DBS check assists employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. Nurses had up to date registrations with the Nursing and Midwifery Council.

Good

Is the service effective?

Our findings

At our previous inspection which took place on 21 and 24 April 2015, we found where there were some unlawful restrictions in place. There was no evidence in the care plans to show that people's capacity to make decisions had been considered before a decision had been made to restrict their liberty. In addition the provider had not applied to the local authority as required for these restrictions to be agreed and authorised in people's best interests.

At this inspection we found that improvements had been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Staff told us that they had training in the Mental Capacity Act 2005 and DoLS which we confirmed from the training records we saw. The staff we spoke with understood the key principles of the Act and said that they put those into practice. One staff member told us that, "Some people in the home had the capacity to make all the decisions about their care." The registered manager said "We do the two stage test on brain function and retaining information."

The provider had introduced a mental capacity assessment form and an evaluation that was completed monthly. Care records included appropriate assessments of people's capacity to make decisions and reflected the fact that people had been involved in making decisions by participating in reviews and meetings. One person told us, "Staff respect my decisions." During meal times we observed staff asking people about their choices of food and drinks.

Some records where people were assessed as not having capacity to make certain decisions about their care and support, showed the involvement of family members and people who knew them well (where appropriate). Records showed their involvement when a 'best interests' decision was made on people's behalf about their care and support. One person was visited by a DoLS assessor and relevant person representative (RPR) on the day of our inspection and we saw documentary evidence that an RPR, along with other professionals had been involved in best interests meetings which had taken place when considering restricting people's freedom to keep them safe.

DoLS applications had been made to the local authority when people were subject to restrictions to their freedom. A list of people that were subject to DoLS was displayed in the main office, with dates of when the applications had been submitted, the outcome and expiry dates. There were 14 people who were subject to DoLS at the time of our inspection.

Staff that we spoke with told us they received regular training. The registered manager showed us an up to date training matrix and also the planned training schedule for 2016/2017. The training matrix listed all the training that staff had attended along with when they had last attended. Training provided was a mixture of in-house, external and e-learning.

New staff completed an induction handbook, covering a number of areas from the provider's policies and procedures, principles of personal care, record keeping and health and safety. New starters also completed training in the following areas: safeguarding, infection control, health and safety, moving and handling, fire safety, food safety, COSHH, equality and diversity, dementia, manual handling, MCA/DoLS, first aid, end of life and slips, trips and falls. We saw managers meeting minutes that showed the provider was looking to implement the Care Certificate for new starters in the future to ensure that staff were equipped with the skills and knowledge to meet people's needs effectively.

Staff told us they had regular supervision and records showed that supervision and appraisals were planned regularly. The staff supervision allocation sheet was displayed in the manager's office. Topics discussed included team work, documentation and effective communications.

Culturally appropriate meals were prepared in the service. The provider only served vegetarian food which people were made aware of when they first considered moving into the service. People told us the food was fine but some said they did not always get a varied choice.

Care records showed that specialists such as the dietitian were involved in the planning and monitoring of the delivery of support to ensure that people's nutritional needs were met. A sheet with people's dietary requirements was on display in the kitchen to ensure that staff were aware of people's needs.

Separate food preparation, hand washing and utensil sinks were available in the kitchen. Daily temperature checks were taken and a weekly kitchen audit was completed looking at any complaints, records, stock control, maintenance and pest control. A kitchen cleaning chart and a food wastage chart was in place. A daily food safety record was kept which recorded the cooking temperature and core temperatures of food to make sure that food safety standards were maintained.

People's individual health needs were met. One person told us, "Today they have already arranged for me to attend hospital for treatment." Another said, "If I feel physically unwell I can see the GP easily." One person with a wound on their foot told us, "The staff change my dressing every other day and I never have to remind them."

Records showed that people's general health checks were done regularly. One staff member told us that "The GP visits regularly" which was confirmed by care notes. Staff told us they worked with other healthcare professionals to ensure that people's needs were met appropriately. We observed the nurse on duty liaising with the pharmacist about medicines and also giving information to the hospital about a person about to have dialysis. We also observed the staff making an appointment for a person during our visit.

There was evidence of involvement of specialist healthcare professionals in people's care. For example, following a fracture a person was referred to the maximising independence team who had recommended limb management and moving and handling techniques which were being adhered to by staff. Records showed the involvement of other professionals such as dentists, chiropodists, psychologists, psychiatrists, district nurses, community dietitians, diabetic nurses, opticians and tissue viability nurses. A multi-disciplinary team (MDT) referral record sheet was kept, documenting referrals that had been made to professionals. One staff member said, "The nurses and other professionals provide us with guidance and

instructions on how to support people."

People with diabetes had their blood sugar monitored regularly. They had care plans that identified the risks and gave instructions to staff. Records indicated that the instructions were being followed and also showed involvement from other professionals such as the diabetic nurse, the district nurse, dietitian and optician. One staff member told us, "[Person with diabetes] has annual eye checks" which we confirmed in the records we saw.

Good

Is the service caring?

Our findings

One person told us that the staff were caring and kind and said, "They never refuse to do anything for you" and "Nobody has ever shouted at me." Other comments included, "All staff are nice here" and "Staff are good, they are polite." A relative told us, "Staff are friendly, they are good."

One care worker told us, "The most important part of my job is to care for the residents and to make sure that they are safe. I care for them by making sure that they have enough to eat and drink and make sure that they don't fall." We observed care workers who were engaged in assisting people with their activities of daily living and supporting people to maintain their independence.

During the inspection we observed caring interactions between staff and people using the service. The interactions were pleasant with staff taking time to listen to people and responding in a calm and relaxed manner. Most of the staff had a good knowledge of people and knew how to communicate effectively with them. For example, one staff member told us that one person was deaf in one ear and said, "You need to get close and speak loud."

Care workers spoke to people in a gentle manner when supporting them with breakfast, asking them "Are you OK?" and "Eat carefully." Care workers took their time assisting people and tried to engage people in conversation. A care worker told us they respected people's right to choose, "We always ask the residents before supporting them with personal care. If they refuse, we come back and try and encourage them."

The provider was meeting the cultural and religious needs of the people using the service. The inspection was taking place in the middle of a 10 day festival called Shubh Navrati. Decorations had been put up for this and families had been invited to partake in the festivities. There were pictures displayed in the home of other festivals that had taken place, such as Janmashtami in August 2016. The decor in the service reflected the religious needs and culture of the people using the service. People were also supported to attend daily prayers.

Records showed that people were asked about their preferences and dislikes when they first arrived at the home and these were incorporated in the care plans. One person told us, "The staff respect my views and I don't have to do anything I don't want to do." This was evident during meal times when we observed a staff member saying to a person who did not want to eat, "Shall I come back later, shall I leave it nearby and see how you feel later."

We observed that people's privacy and dignity was respected. Staff closed the door during personal care and knocked on people's bedroom doors before going into the room. They respected their choice of clothing and also how they wanted things arranged in their rooms. One person told us, "I can have my door closed when I want to."

Good

Is the service responsive?

Our findings

At our previous inspection which took place on 21 and 24 April 2015, we found care and treatment did not always meet people's needs.

People's needs were assessed and care plans developed, however their individual needs were not always fully met. Some of the care plan reviews did not always reflect the current support needs of people using the service.

At this inspection we found that improvements had been made.

We saw that one person had a food and fluid chart to monitor their nutritional intake and we saw that this was completed correctly. One person on a 24 hour fluid balance chart similarly had all their records updated with the amount of fluid they had been given over a 24 hour period. We saw the records of four people on a pureed diet, staff completed food charts on a daily basis with sufficient amount of detail, for example quantities eaten, if refused and how much offered. There was a personal hygiene chart available on each floor, which showed that people had their personal care needs taken care of.

We observed that one person had a turning chart so that staff could record and monitor that the person was re-positioned at the required intervals to help prevent the development of pressure sores. In their sleeping care plan it stated that they needed to be turned every two to three hours, we checked the turning charts for this person and they were completed appropriately. They had a waterlow risk assessment on which it indicated they were at high risk of developing pressure sores which was reviewed monthly. They had a pressure sore and pressure ulcer management care plan.

People's needs were assessed prior to admission and care plans were devised with the involvement of the person, their relatives, and other professionals where relevant. Care plans were individual to people and were reviewed on a monthly basis. These included information on the person's needs, goals and required nursing intervention. One person told us, "The home provides me with the care that I require and I cannot ask for more than that."

People were allocated a named nurse and a key worker. Records showed that relatives contributed to meetings and reviews where appropriate. All care notes were neatly organised in a file with an index of the different sections. Each file had the person's photograph with the appropriate consent signed by the person or their relative if appropriate.

Residents' and relatives' meetings dates were on display in the service. These were scheduled to take place in March, June, September and December 2016. The minutes of the meeting held in March 2016 were attended by families of 11 residents. A guest speaker was arranged but was unable to attend, other items discussed included future events, advance care plans, furnishings and diet. The minutes from the June meeting items discussed included the building, activities, the Gold Standards Framework (GSF) and staffing. The September meeting had been cancelled and the registered manager told us they had delayed it until

October.

People were provided with the opportunities to engage in activities at the home. On the day of the inspection the building was decorated and activities organised to celebrate a festival and there was chanting and dancing to remind people of the festival and the staff encouraged people to partake in the festivities. The activities co-ordinator said, "In June we had a picnic in the park, we sent an email to relatives to join us. We hired a minibus." A staff member showed us a scarf she was helping a person using the service to knit.

The activities co-ordinator worked during the week but told us they often came in on weekends if there were specific events or festivals arranged. They said that relatives usually visited on the weekends and took their family members out hence there were fewer planned activities on the weekend. An activity board was used to advertise activities.

People had regular group and individual sessions with the activity co-ordinator during week days. The activities co-ordinator said, "Most of the residents stay in their rooms so I go to their rooms and spend time with them. I go and see each person every day" and "The care workers are busy but if I need help they will help, if I'm arranging an activity they will bring people down to the lounge."

People and their relatives said they did not have any current concerns and when they had complained in the past, they were listened to. The complaints policy summary was on display in the reception area and this provided details of how the complaints were received, timescales and the escalation process. It also contained details of the Care Quality Commission and the Local Government Ombudsman (LGO an external organisation that people can go to to make complaints about adult social care services).

We looked at the records for complaints that had been received in the past year. There was evidence that where concerns were raised the provider took action and responded to the complainant appropriately.

Good

Is the service well-led?

Our findings

At the previous inspection, the registered manager was in the process of applying for the post and we found that staff morale was low and staff did not always feel supported.

Since the previous inspection, the registered manager's application for the post had been processed and their registration approved. Staff that we spoke with felt supported and told us the registered manager was approachable and a visible presence in the service which we observed to be the case during the inspection. The staff told us they were supported by the registered manager to attend training courses. They told us they were able to ask the manager for advice when needed. Comments included, "The manager is like one of us, she works with us and is very understanding", "I'm happy here, I enjoy it", and "The manager is very helpful."

Staff said that they worked well together as a team and were aware of their responsibilities. They completed daily records such as personal hygiene, food and fluid charts and attended a daily handover meeting between shifts to ensure that appropriate information was shared amongst the team as required.

We observed the handover meeting which was very thorough and there was a good exchange of information for each person, how they were feeling, any upcoming appointments and what support they needed.

The registered manager told us that staff meetings were held monthly but documented minutes of these were not available. We only saw the minutes from March and May 2016. The registered manager held meetings with other registered managers for the provider's other locations every six to eight weeks, topics covered reflective practice, updated policies and procedures and changes to training.

We reviewed the incidents and accidents that had occurred within the service over the past year. These were recorded and appropriate action was taken by the provider in response to these incidents, for example referrals had been made to the falls clinic and other healthcare professionals.

Audits included monthly monitoring visit reports which were based around CQC inspections and carried out by the quality care manager. This helped the provider to drive and maintain the service it provided to people. The provider also carried out regular audits on medicines, wound care and infection control. They had action plans which were up to date and the registered manager told us that she shared the information from these audits at clinical staff meetings.

The provider also carried out regular checks on equipment within the home and the environment. We saw current certificates for legionella testing, inspection for fire extinguishers, fire alarm, emergency lighting and gas safety. Equipment such as hoists and slings were checked weekly.

The nurse call system had also been recently checked and there was a deep clean to kitchen equipment and structure that had taken place in June 2016.