Karuna Care (TLC) Limited

Karuna Manor

Inspection report

Christchurch Avenue
Harrow
Middlesex
HA3 5BD

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25 October 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We undertook an unannounced inspection on 25 October 2016 of Karuna Manor. Karuna Manor is a care home registered to provide accommodation for people who require nursing or personal care. They are registered to provide care for a maximum of 60 people who may be living with dementia. There were 29 people using the service at the time of our inspection.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission [CQC] 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. The registered manager had resigned since the last inspection and an interim manager was managing the home until a permanent manager was appointed.

At our previous inspection of 19 May 2016, we found the provider failed to maintain an accurate, complete and contemporaneous record in respect of the care and treatment provided to people using the service, people were not adequately protected from the risks of unsafe medicines, and management and quality assurance systems and processes in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people.

This meant the provider was in breach of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider sent us an action plan setting out the actions they would take to meet the regulation. During this inspection we found action had been taken to meet one of the regulations. Records showed appropriate arrangements were in place in relation to the management and administration of medicines. However we still found issues with record keeping and audit processes were not robust enough to facilitate improvement in the quality of care being provided.

People's care plans were person-centred, specific to people's needs and detailed the support people needed in various areas of their care. However, some areas were poorly written so very difficult to read. Staff were not completing daily monitoring charts accurately and these were not being checked and countersigned by a nurse or senior member of staff to ensure the needs of people were being met.

Some audits were conducted. However, they were limited to checks being undertaken. There was no effective evaluation of the quality of service being provided to people and action plans in place to enable improvement.

There was a lack of leadership in the home and poor communication with people and relatives. Unit managers for each floor were being appointed to address this.

Since the last inspection the registered manager had resigned and a number of care workers had also left. During this inspection we found the provider had taken action to reduce the use of agency staff by employing more permanent staff to ensure consistency in people's care.

People and relatives of people using the service told us that they were confident that people were safe in the home.

Systems and processes were in place to help protect people from the risk of harm and staff demonstrated that they were aware of these. Staff had received training in safeguarding adults and knew how to recognise and report any concerns or allegations of abuse.

People's care needs and potential risks to them were assessed. Risk assessments had been carried out and staff were aware of potential risks to people.

Staff were caring and knowledgeable regarding the individual choices and preferences of people. Records showed that staff had received training to enable then to carry out their roles.

Staff we spoke with had an understanding of the principles of the Mental Capacity Act (MCA 2005). Capacity to make specific decisions was recorded in people's care plans.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS ensure that an individual being deprived of their liberty is monitored and the reasons why they are being restricted is regularly reviewed to make sure it is still in the person's best interests. The home had made necessary applications for DoLS and we saw evidence that authorisations had been granted.

There were some activities available for people using the service. The activities plan for the home included generic activities such as ball games, exercises and bingo. However some relatives told us activities were not physically or mentally stimulating.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered manager to take at the back of the full version of this report.

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. People who used the service and relatives we spoke with told us people were safe.

Staff were aware of different types of abuse and what steps they would take to protect people.

Risks to people were identified and managed so that people were safe and their freedom supported and protected.

Appropriate arrangements were in place in relation to the management and administration of medicines.

Is the service effective?

Good

The service was effective. Staff had completed training to enable them to care for people effectively. Staff felt supported by their peers and management.

There were arrangements in place to obtain, and act in accordance with the consent of people using the service.

People had access to healthcare professionals to make sure they received appropriate care and treatment.

Is the service caring?

Good

The service was caring. We observed positive interaction between staff and people using the service.

People were treated with respect and dignity.

People were supported to maintain relationships with family members and people that mattered to them.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Complete and contemporaneous records had not been kept about people's care.

There were activities available for people. Some relatives told us

but they were not physically or mentally stimulating or specific to people's cultural needs and preferences.

Care review meetings were being undertaken to review people's needs and develop their care plans.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. The leadership and management structure were not effective in making sure people received a good quality of service at all times.

There were systems in place to check certain aspects of the home however we found some deficiencies in the service had not been identified or effectively addressed.

There were improvements made in the management of medicines and staffing arrangements in the home.

Karuna Manor

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

We undertook an unannounced inspection on 25 October 2016. The inspection team consisted of two inspectors, a pharmacist inspector and a specialist advisor.

Before we visited the home we checked the information that we held about the service and the service provider including notifications about significant incidents affecting the safety and wellbeing of people who used the service.

We had received information on a number of safeguarding issues concerning people's care. These related to staff, medication errors, poor clinical management, quality of food and activities and lack of effective management in the home. We carried out a comprehensive inspection in response to these concerns

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing

We spoke with ten people using the service and twelve relatives. We also spoke with six care workers, four nurses, unit manager, project manager, interim manager and the operations director.

We reviewed eight people's care plans, ten staff files, training records and records relating to the management of the service such as audits, policies and procedures.

Good

Is the service safe?

Our findings

People using the service told us they felt safe in the home. They told us "It is quiet and nobody disturbs me or comes in my room. I keep to myself. I can't fall out of bed because I have got bedrails. When I require assistance I use my bell and the staff help me", "I feel safe here" and "Every night they come and check on me."

At our 19 May 2016 inspection, we found medicines problems and a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider sent us an action plan setting out the actions they would take to meet the regulation. During this inspection we found that the provider had followed their plan and legal requirements had been met. The provider had taken action to address our concerns about the way medicines were managed by the service.

At this inspection, we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in a locked medicines trolley (within a locked room). When the medicines trolleys were not in use, they were secured to the walls.

Current fridge and room temperatures were taken each day (including minimum and maximum temperatures). During the inspection (and observing past records), the fridge temperature was found to be in the appropriate range of 2-8°C. This assured us that medicines requiring refrigeration were stored at appropriate temperatures to remain effective.

People received their medicines as prescribed, including controlled drugs. We looked at fifteen MAR charts and found no gaps in the recording of medicines administered, which provided a level of assurance that clients were receiving their medicines safely, consistently and as prescribed. However, we also found that there were some double entries on the MAR chart. Although these had been clearly crossed out in an appropriate manner, this could have the potential to confuse staff administering medicines.

We spoke with one person who reported that they received their medicines in a timely and correct manner. Running balances were kept for medicines that were not dispensed in the monitored dosage system. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed (one or two paracetamol tablets), we saw a record of the actual number of dose units administered to the client. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this.

Medicines to be disposed were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs [CDs] were appropriately stored in accordance with legal requirements, with daily audits of the quantities of CDs carried out by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour were not controlled by excessive or inappropriate use of medicines. For example, we saw eight PRN forms for pain-relief/laxative medicines. These were mostly appropriate, there were up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit. However, we found that there were some discrepancies in some of the PRN forms. For example, for one person, we found that their new pain relief dosage had not been updated on a new PRN form. Also, for another person, we found that there were 2 different PRN forms for the same medicine. This had the potential to cause confusion to staff administering this medicine, and thus introducing risk. Finally, we found that 5 PRN forms for medicines were missing (for different people). This meant there was a risk that staff were not able to give these medicines in accordance with instructions determined by the prescriber. We were informed by the provider that they were currently replacing all the PRN forms for people with an improved type. We saw evidence of this during the inspection, an example of which included a section on how to recognise verbal signs of pain from residents so that they could be administered their pain relief medicines appropriately.

Medicines were administered by nurses and carers that had been trained in medicines administration. We found evidence of where their medicines competencies had been checked recently. Staff were also able to demonstrate competence. For example, they were able to inform us about how to manage medicines incidents appropriately.

We observed a medicines' round and found that staff had a caring attitude towards the administration of medicines for people. They waited until people had taken their medicines. Also, we saw that staff on the ground and second floor wore a protective vest to ensure that they were not disturbed during the medicines round. We found that a member of staff did not wear a protective vest on the first floor when administering medicines. However, they were not disturbed during the medicines round we observed.

We looked at two MARs for people who were administered their medicines covertly. We found that both people had the appropriate authorisation and input from professionals to enable them to have their medicines covertly. For example, there was evidence of a best interests meeting, DOLS, mental capacity assessment and a covert medicines form signed by the GP and pharmacist. This assured us that people in the home were administered medicines covertly in an appropriate manner in accordance with legislation and recommended guidance.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the supplying pharmacy and the provider, including safe storage of medicines, room and fridge temperatures and checks of quantities of stock medicines on a daily basis.

We found that the provider was appropriately monitoring the risk of medicines. For example; we found evidence of rotation patch application records for medicine patches that required rotation, warfarin dosage administration records, midazolam (a high risk medicine used for sedation) administration instructions, falls risk assessments for medicines and monitoring of blood glucose levels for those people prescribed diabetic medicines. This assured us that the provider made suitable arrangements to ensure service users were protected against the risks associated with taking medicines.

The provider confirmed they were happy with the arrangement with the supplying community pharmacy and GP, and felt that the provider told us they received good support from them with regards to the training of nursing staff in medicines administration and medicines reviews. This was evidenced by checking the record of several medicines reviews that had been carried out within the last 2 months for people. Where a

GP had amended a medicine, we saw evidence of an 'important medication changes 'form filled out appropriately for that person, with the corresponding medicine ordered and administered on time. People told us that they had their medicines on time. One person told us that "I am very pleased that all my [medicine] is available to me and I get them whenever I need them. This makes my pain manageable. Things have improved quite a lot" and "I get my medicine on time."

People's care needs had been assessed. Care plans we reviewed included relevant risk assessments which covered various areas of people's care needs such as falls, bed rails and moving and handling. Since the last inspection, we received concerns from some relatives about the way manual handling was conducted in the home. During this inspection, training records confirmed staff had received refresher manual handling training and staff confirmed this. Staff told us that they had training in moving and handling which included the use of bedrails and hoists. Care workers told us "People who are at risk of climbing over the rails are provided with low profiling bed with crash mattresses" and "We get the training which includes moving and handling."

Assessment of skin integrity and wound management had been completed. The Waterlow assessment tool was used for pressure ulcer risk assessment. Records for one person using the service showed that body maps and photographs were taken to monitor and manage their wounds. People with the risk of developing pressure ulcers and those with wounds were nursed on an air-mattress and staff supported people to regularly change their position to relieve pressure on their skin. There were repositioning charts in place that demonstrated people had changed their position in accordance with the instructions on the care plans. It was evident that the service had identified individual risks to people and put actions in place to reduce the risks. Another person who was at medium risk of falls had bedrails with bumpers to prevent risk of entrapment fitted to their bed. There was a bedrails risk assessment in place. There was also a care plan to provide staff with guidance to prevent and minimise the risk of falls to the person. Examination of the bedrails showed that they were appropriately fitted.

The Malnutrition Universal Screening Tool (MUST) risk assessment was being used to assess people with a history of weight loss or poor appetite. People's weight was monitored and recorded monthly. Records also showed a dietician was involved in the care of people with potential risks with their nutritional and hydration needs. We reviewed a person's care who recently received nutrition via a tube into their stomach [Percutaneous endoscopic gastrostomy] (PEG) feeding. The management of the PEG was consistent with good practice. There was information to provide guidance for the staff. The relative of the person also confirmed the improvement in the management of the PEG.

During the inspection, we tested the call bells and response times. We found care workers responded in good time. We observed people had call bells in their rooms which were accessible to them. People also had pendants that they wore which ensured they were able to call for assistance wherever they were around the home. Each care worker has a pager and the use of a phone which indicated where the call originated from so they knew where the person was and respond promptly. Feedback from people indicated call bells were being answered. They told us "If I need help, they come quickly I have my call bell here", "There are enough staff here. They come promptly when I press the buzzer" and "I can't remember the last time I was unhappy about having to wait for a long time. In the morning sometimes I have to wait. I find this reasonable because there are so many of us and the staff always tell me when I shall have a bath. They are very kind."

However, some people told us there were issues at night. One person told us, "Night staff are not very good and don't answer the bell", "I would like more carers. They do respond to the call bell – sometimes they are slow." A visitor at the home told us "Sometimes [person] is desperate to go to the toilet, but staff do not respond promptly." Since the last inspection, we received concerns from relatives that people were having

to wait some time before call bells got answered and some call bells were switched off.

We found the home has an electronic system in place which showed the number of calls and the response time to each call. We found this information was not being monitored or audited to ensure call bells were being responded to in reasonable time, followed up to identify reasons for any delays or plans set up to improve the response times. The interim manager sent us information about call bell waiting times after the inspection. This showed that the average response time to attend a call on the ground floor was 2 minutes 4 seconds, for the first floor was 3 minutes 47 seconds and the second floor was 6 minutes 28 seconds. The longest response time to respond to a call was 17 minutes 48 seconds. The project manager told us they would review this to ensure regular monitoring was undertaken of response times.

We asked whether night checks were being completed. Shortly after the inspection, we were sent copies of two night visit evaluation forms dated. 27/05/16 and 22/07/16. These forms detailed findings of unannounced visits conducted by members of the management team. We noted that the findings detailed a number of instances in which documentation was not being completed by staff. Actions to follow up were listed however we were not provided with any further information informing us that any night visits had been conducted since July 2016.

Since our 19 May 2016 inspection, many staff had left and a large number of agency staff had been deployed to fill the gaps. This led to concerns being raised by some relatives and an increase in safeguarding incidents. At the last inspection, we raised concerns about the use of agency staff and the lack of consistency people may receive with their care. The operations director told us they have been actively recruiting staff and the number of agency staff in the home had reduced. The majority of staff including the registered nurses were now permanent and records confirmed this. There were concerns raised by some relatives that there were no managers at the home during the weekends. To address this, the interim manager told us they now had members of the management team working at weekends to ensure a manager was on site to promptly deal with matters should they arise.

On the day of inspection there were adequate staff to assist people with their needs. The atmosphere was calm in the home and staff were not observed to be rushed or under any pressure. We looked at the staff rota and discussed staffing levels with the registered manager. On the day of the inspection there were a total of 29 people using the service. The home has three floors. There were ten people, a unit manager and two carers on the residential floor, thirteen people two registered nurses on the nursing floor and six care workers. There was also an additional nurse who was on their induction. On the dementia floor there were six people, a recently appointed unit manager and two care workers.

Feedback from people, relatives and staff indicated there had been some improvement with the staffing levels. One person told us "They are enough staff now, initially there wasn't." One relative told us that "Back in April [person] had to go looking for a staff when nobody responded to the call bell, however, I am pleased to say that this has not happened since". When speaking to this person they also confirmed this. However some people did tell us "A little more staff needed day and night" and "Sometimes there is a shortage of staff. The day is okay but at night they may be short of staff."

At the last inspection staff told us although they are allocated to a particular floor, they also helped on other floors when required due to the lack of staff in the home. Feedback from staff indicated that this had now improved. Care workers told us "Things have improved now. We have sufficient staff on duty and we seldom have to help each other on the other floors. There are a number of staff that have recently started and this is good", "I am always working on this floor. Things have got better. We have enough staff. Everything is settled here" and "Rotas are on time and we have permanent staff. We have staff that know about people's care"

and "Every month we get the rota."

There were effective recruitment and selection procedures in place to ensure people were safe and not at risk of being supported by people who were unsuitable. We looked at the recruitment records for ten care workers and found appropriate background checks for safer recruitment including enhanced criminal record checks had been undertaken to ensure staff were not barred from working with vulnerable adults. Two written references and evidence of their identity had also been obtained.

There were safeguarding and whistleblowing policies in place and records showed care workers had received training. Staff had knowledge and skills to recognise potential abuse to people. They were able to describe the actions they would take if they witnessed an abuse. One care worker told us "First I would provide support to the person, then I would report it immediately to my manager to ensure that it is reported to the right authority, I would then document what I witnessed and the action I took".

There was a record of essential maintenance carried out. These included safety inspections of the portable appliances, hoists, lifts, gas boiler and electrical installations. The hot water temperatures had been checked and recorded. The registered manager told us the water temperature was controlled to ensure the water temperature did not exceed the recommended safe water temperatures. Records showed fire equipment was checked to ensure it was in working condition. The home had a fire risk assessment and a general evacuation plan in place. Fire equipment was appropriately stored and easily accessible in the home. The home also had an emergency grab bag. All the residents had a Personal emergency and evacuation plans (PEEP) plan in place in case of fire.

Good

Is the service effective?

Our findings

Generally we received positive feedback about care workers from people and relatives. People told us "Staff are respectful". Relatives told us "We know the carers quite well. They are very co-operative", "[Staff] have been brilliant" and "Care workers are good, they talk to [person] and [person] is getting the care they need." One visitor to the home told us "The staff do what they are supposed to do."

Staff told us that they felt supported by their colleagues and management. Care workers told us "It is nice here and a good team, very cooperative", "We work together and help each other" They [management] do listen and resolve our problems", "Our manager is very good, any problem, you can ask them and they explain it very well to you", "Everything is nice. All the staff help with everything" and "We are all equal here, that's why we feel that we want to come to work."

We looked at staff records to see how staff were supported to carry out their jobs effectively. Records showed that staff had undertaken an induction when they started working at the service. Training records showed that staff had completed training in various areas relevant to people's needs which included pressure area care, COSHH [Control of Substances Hazardous to Health], fire prevention and awareness, infection control, food hygiene, dementia awareness, health and safety and basic life support. Training also included competency assessments in areas such as moving and handling and medicines administration. There was a training matrix in place which clearly showed what training staff had completed and when their next refresher training was due.

During this inspection, feedback about staff was generally positive however one person told us "Some staff were good while others were not so good." One relative told us "There are some good staff but it is not consistent. We need more quality and consistent staff across the home."

Records showed evidence that staff had received supervision sessions which enable staff to discuss their personal development. There was a supervision matrix in place which showed supervisions had taken place in June 2016 and some in October 2016. However there was no evidence to demonstrate spot checks had been undertaken to monitor staff's performance and ensure people were receiving consistent quality care throughout the home.

Since the last inspection, we received concerns from some relatives that staff were not knowledgeable about clinical issues and did not have the skills to fully care for residents. Some of the feedback related to agency staff that had been employed by the home previously however some feedback related to the permanent staff currently employed. There was some evidence to demonstrate action had been taken by management when practice issues with staff had arisen. One relative told us "We had an issue about one care worker who was abrupt and rude in their manner but this has been resolved." However some relatives remain dissatisfied with the performance of some members of staff in the home.

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.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We noted that care plans contained information about people's mental state and cognition. Where there were areas in which a person was unable to give verbal consent, records showed the person's next of kin and relevant health professionals had been involved to ensure decisions were made in the person's best interest.

Staff told us that they had received training on the Mental Capacity Act 2005 and DoLS. Staff we spoke to understood the key principles of the Act and said that they put those into practice. One care worker told us that "Some people in the home have the capacity to make all the decisions about their care." One person using the service told me "Staff respect my decisions."

Records showed the registered manager had applied for DoLS authorisations for the people using the service. We saw the relevant processes had been followed and standard authorisations were in place for people using the service when it was recognised that there were areas of the person's care in which the person's liberties were being deprived.

People's care plans contained information regarding their medical conditions and whether they had any allergies. Records showed that people's general health checks were done regularly. One care worker told us that "The GP visits regularly" and records confirmed this. One person using the service told us "If I feel physically unwell I can see the GP easily". During the inspection, we observed staff making an appointment for a person who wished to see the doctor. Records showed the involvement of other health professionals such as the dentist, chiropodist, psychologist, psychiatrist, district nurse, diabetic nurse and tissue viability nurse.

People using the service spoke positively about the support they received with their health care. They told us "The GP visits weekly. If it's urgent, he comes. The chiropodist also comes. I have also seen the consultant in the hospital"; "I had not been feeling well. The doctor has seen me"; "I am feeling better. I have physiotherapy. I am starting to mobilise" and "I have seen the GP." One visiting healthcare professional also spoke positively about the home and told us "Staff inform me if there are concerns. Staff usually follow instructions. The resident has made progress and can now stand up."

Care records showed that nutritional needs of the people who used the service were assessed. People's weights were recorded monthly so that the service was able to monitor their nutritional requirements, and there was information about people's nutritional needs in their care plans, which included details of the support they required from staff to eat and drink. Care records showed that specialists such as dietician, Speech and Language Therapist (SALT) and diabetic nurse were involved in the planning and monitoring of people's nutritional needs to make sure they were met. Malnutrition Universal Screening Tools (MUST) were completed on admission and reviewed monthly.

People with diabetes had care plans in place that showed there had been involvement from a dietician and a diabetic nurse. Records showed that their blood sugar levels were checked and recorded both by day and night nurses. There were annual recorded checks by the optician and frequent checks by the chiropodist to monitor people's health and minimise health risks associated with diabetes. There was clear information available in the notes for staff to recognise the signs and symptoms of hypo/hyperglycaemia [low and high

blood sugar levels] and the actions they should take in response to these.

People we spoke with during the inspection spoke positively about the food. They told us "The food is very nice. Whatever, food I like, they can cook it", "The food is like home cooked food. Good healthy and well balanced. We get fresh fruits and vegetables. They don't economise", "The food is okay" and "The food is good." Relatives told us that "The food and the environment is first class and there is plenty to go around. I have never had to bring food from home out of concern about the quality of food", "[Person] is happy that they get vegetarian food and this is catered for them. [Person] doesn't eat eggs and we don't have to worry about that either" and "They are good and cater to [person's] needs especially the food and staff speak the same language which is a great help."

Some relatives did tell us that they were not satisfied with the quality of food. They told us the food could sometimes be oily and was not nutritious enough. The chef told us they got information about people's needs and what they like. They also were aware of peoples' dietary needs if food needed to be softened or if they have diabetes. A manager told us that the menu was changed based on people's preferences and what they liked and alternative menus were available.

During the inspection, we observed that there was a selection of drinks both hot and cold being offered to people throughout the day. We observed people having their lunch on each of the units. Specific dietary requirements for people had been accommodated for such as pureed foods and there were aids to assist people with difficulty in drinking like special cups with large handles, beakers, and straws. There was a variety of food available, which was well presented. People appeared to be enjoying the food and people ate all their meals. The tables were well laid and people were seated comfortably and appeared relaxed. People sat with other residents in the home and engaged in conversation with each other.

There were enough staff to assist with the serving of the food and to provide people with support people when it was needed. We observed staff were attentive and asked people about their choice of food and drinks. One care worker we observed supported a person with their meal, sat next to them and assisted them to eat in an unhurried manner. Another care worker was sat with two people and gently encouraged and prompted people to eat their food and provided support when it was needed.

However, we observed some staff on the nursing floor were task focused and their engagement with people was very limited. They would concentrate more on the tasks at hand such as placing people's plates on the table and washing up. We observed one instance in which the behaviour of a care worker was poor and showed a lack of respect and dignity for people. A person said to the care worker that the dessert was cold and they would like it to be reheated. This was completely ignored by the care worker. The person initially spoke to the care worker in Gujarati which was ignored and then the person then repeated their request in English. This was ignored again by the care worker who then went onto feed the person the cold dessert. The person expressed discomfort and eventually pushed the plate away and gestured they didn't want it. We raised this instance with the project manager who told us they would look into this matter.

The home was clean and well lit. The corridors were spacious which allowed for easy use of wheel chairs and they were fitted with rails to aid mobility. The corridors were well sign posted and the passages were free from obstructions. The rooms were tidy and cleaned every day and were accessible to wheel chairs and hoists. People and relatives told us that the rooms were cleaned everyday. One person told us " My room is cleaned everyday, you can see it is not cluttered. My clothes are washed immediately and returned to me. They don't store dirty clothes in the room". There was an infection control policy and measures were in place for infection prevention and control. A cleaning schedule was in place which allocated cleaning responsibilities to housekeeping staff to ensure that the home was kept clean at all times.

Good

Is the service caring?

Our findings

People using the service were generally positive about the care workers and the care they received. They told us "The staff are polite and kind.", "I am well treated.", "I get a shower every day" and "I am sick. They look after me. They are good." Relatives also told us "I am so happy with the care. I am really happy", "We can sit with them here and eat with them. [Person] is getting quality care", "The care is fine overall, they do look after the residents. Care workers do listen" and "[Person] is cared for very well." One healthcare professional told us "Staff are respectful."

During the inspection, with some exceptions, we observed people were relaxed and were free to come and go as they pleased in the home. Care workers were patient when supporting people and attentive towards people's needs. We observed some caring interactions during the inspection, care workers spoke to people affectionately and respectfully.

The care people received was person centred. We observed on the dementia floor, two people having a late breakfast. A person's relative told us "This morning [person] wasn't well. They took their temperature and checked their blood pressure which was high. They called me and it was a joint decision about what we should do. Because [person] wasn't feeling well, [person] has to have their breakfast late and this was accommodated for them."

Shortly after the breakfast, two care workers sat with the other person and prompted the person to sing a song which the person smiled and joined in. The person was sitting near the window and was pointing out towards the road. A care worker told us "[Person] likes to look outside the window and look at the bus. [Person] used to be a school teacher and when the bus goes pass [Person] will say look there is the school bus."

By mid-morning almost all residents had their personal care attended to, had their breakfast and administered their morning medicine. Most of them were attending the morning prayers and a few people were resting in their beds comfortably. One person told us "I arranged to have the night nurse to support me to have a bath early this morning, the carer helped me getting dressed and after breakfast I had my medicine and went for prayer. I returned because I felt I needed to rest. The staff was good and I did not have to wait".

All bedrooms were for single occupancy and had ensuite facilities. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as photographs and ornaments, to assist people to feel at home. People's cultural and spiritual values were fully respected and accommodated for. People had access to Indian channels and were able to watch Bollywood films if they wished to. There was a Mandir (Hindu Temple) on the ground floor which enabled people to do their prayers and sing Bhajans (religious hymns) in the morning and evening. The home also has a resident Hindu priest. People using the service told us "I like it here. They look after me. They take me the prayer room. The staff are very nice" and "I am happy with my bedroom. The home is clean, hygienic and tidy. The garden is nice. Someone takes me to the garden."

We observed people were supported to maintain relationships with family members and people that mattered to them. Throughout the inspection, we observed family members came to see people and were able to sit with them and stay at the home with their family member as long as wanted without being disturbed or without restriction.

We observed staff respected people's decisions and their privacy when they wanted to stay in their rooms. Staff we spoke with had a good understanding of the importance of treating people as individuals and respecting their dignity. Staff closed the door during personal care and knocked on the doors before going in the room. People using the service told us "They protect my privacy" and "We get baths and showers. They do it in a private and respectful way."

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 such as what times they like to wake and go to sleep and what name they preferred to be called. One person told us "I can be difficult at times, but nothing is too difficult for the staff. Most of them shows respect when they assist me during personal care. They wait, however long it takes for me to wash myself. This has taught me patience".

During this inspection, we observed most people using the service spoke Gujarati and some people could also speak and understand English. Relatives told us it was an advantage that staff were able to speak Gujarati in the home. Although not all staff were able to speak Gujarati, we observed there were enough Gujarati speaking available to assist if needed. We observed two examples of this during the inspection and good team working amongst care workers to ensure people were listened to and understood. During one interaction with a person addressing a non Gujarati speaking member staff, the care worker sought assistance from another staff whilst asking the person to wait until the other care worker came. During lunchtime, we observed a member of staff who was unable to understand what one person was saying. We observed the staff member slowly and patiently explained to the person that she did not understand but would get someone who could help. The Gujarati speaking staff member explained what the person wanted but the non Gujarati speaking staff asked them to explain to her again what was said so this would help her to understand the person next time.

We received positive feedback about the way care workers communicated with people. For example people told us "The staff can communicate and they listen to me" and "Communication is not a problem. Some staff talk Gujarati, some English." One relative told us "Being able to speak Punjabi and Hindi is helpful, what I care most is the care [relative] receives from the staff, I come here everyday and the care [relative] receives from the staff is generally good irrespective of the language they speak."

Since the last inspection, we received concerns from some relatives that some staff could not speak Gujarati and their mannerisms were rude and abrupt. Concerns were also raised about the lack of confidentiality in the home. People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. However, some relatives told us that staff including unit mangers would speak to relatives about people's needs in open areas such as near the reception areas of each floors where other relatives and staff could hear what was being said. One relative told us "They don't keep the confidentiality about concerns or issues you have raised. Everybody knows everything." During the inspection, we did observe one instance where a relative was speaking about their relatives needs with staff and the unit manager in the open reception area on their floor and parts of the conversation could be heard in the dining area.

The manager told us it was very difficult to recruit staff that were all Gujarati speaking. We discussed with the project manager that the main issue was to ensure that all care workers whether Gujarati or not spoke and

behaved with people in a dignified and professional manner and was consistent throughout the home. This could be managed through regular spot checks of staff in the home. The project manager told us they would ensure this would be reviewed.

Requires Improvement

Is the service responsive?

Our findings

During the inspection, people and relatives spoke positively about the service. One person told us "The home is well run. I can't complain much. I have not made a complaint". Relatives told us "[Person] has improved here and is a lot more responsive and I am happy about that" and "No issues with the care. They have a handle on things. They let me know if anything is wrong." [Person] is happy at the moment and has settled in well. They do inform me if something is wrong."

At our inspection on the 19 May 2016, we found the provider was not maintaining accurate and contemporaneous records about people's care and support. This placed people at risk of receiving inconsistent and inappropriate care and was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider sent us an action plan setting out the actions they would take to meet the regulation. During this inspection we found there were still concerns with some record keeping in the home and monitoring of people's needs. Staff were not completing records accurately and daily monitoring charts were not being checked and countersigned by a nurse or senior member of staff to ensure the needs of people were being and met.

We found the information in people's care plans were person-centred, specific to people's needs and detailed the support people needed in various areas of their care such as health, social, personal care, mobility, medical, religious and communication needs. Care plans were reviewed monthly by staff. However the monthly reviews were handwritten by staff and it was very difficult to read what was written. There was inconsistency in that some care plans had been signed by people using the service and relatives and some had not, which could mean that some people had not had the opportunity to read and be involved in their care plan.

Daily records were not being completed accurately. For example records showed people were receiving adequate daily amount of fluids. However, the daily records did not consistently calculate the daily targeted amount and they were not totalled by the end of the 24 hours.

In one care plan it was noted that the person should be supported to be turned and repositioned every three hours to avoid the risk of developing pressure sores. Daily records showed staff had documented their actions on the repositioning sheet to confirm this. However, the quality of the recording was not always clear. In a number of recordings the care workers had written over mistakes instead of crossing them and re-writing them so it was sometimes unclear which position the person had been moved and when. The charts had not been checked and countersigned by the nurse or senior member of staff.

In another care plan the staff had recorded the actions they had taken in the treatment of a pressure ulcer. This person told us about the ulcer and stated "It is much better." One care worker told us "We get a lot of advice and help from the tissue viability nurse." The progress of the wound could be seen by a photograph that had been taken. However, there was one photograph due to have been taken 3 weeks ago that was

missing. We enquired about this and we were told by staff "It was taken but due to technical difficulty it could not be retrieved from the camera". We were then shown the picture fifteen minutes later after we had enquired. This has not been followed up any member of staff that the photograph was missing which meant records did not accurately reflect the care being provided to this person. The charts had also not been checked and countersigned by the nurse or senior member of staff.

Photographs and body maps were also used to show the areas for the applications of body creams. Records showed these were not always completed. In some daily charts there were a number of gaps in the recording of the application of creams, which could indicate that people were not always receiving their prescribed topical medicines. For one person, the nurse told us" I know that the carers have applied the cream, but have not recorded it". We were also told by another nurse that they didn't check and countersign the charts.

We also found there was no effective leadership and clear managerial structure in the home to ensure people's needs were being monitored, records were accurate and people's needs were being met. We found roles were unclear and there was no overall ownership for their roles and record keeping. This may indicate why records are not being completely accurately and consistently.

Care workers told us that the care notes include guidance and instruction from nurses and other professions on how to support people. However mostly they told us they relied on the daily hand-overs where they received most of the instructions about meeting people's care needs. Care workers told us "When you have been here for so long you know what you need for the residents. I must admit that I have not looked at the care plans for a long time" and "I am not always allocated to the resident I am key worker to when I am on duty. We get the information we need during handover." Care workers also told us that once they have been allocated care duties they work unsupervised. One care worker told us "The nurses sometimes help but they are too busy themselves. I don't have anybody observing my work and giving me feedback".

The above evidence demonstrates there were still issues with record keeping in the home. Staff were not completing records accurately. There was no effective management structure to ensure records were being checked to ensure accurate and contemporaneous records were being recorded and people had received the care and support they needed on a daily basis.

This is a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed some involvement from relatives and they told us issues were not actioned or they had to keep chasing things to happen. The interim manager told us they had started to implement care review meetings with people using the service and relatives. When speaking to relatives they confirmed they had attended or were due to have a meeting in the near future. Relatives told us "We recently had a care plan review. [Staff] made suggestions to help [person] get better", "Not seen the care plan we have a review meeting coming up" and ". They listen to the family's needs as well I have just got a letter for a review." One person told us "They have reviewed my care."

There was an activities co-ordinator. However, since the last inspection, the activities co-ordinator had left. Care staff had taken over this role. There was an activity programme displayed on the reception desks on each floor. People using the service attended prayers in the morning. The priest also visited people who could not attend the prayer room. We were told by staff that people would be involved with exercises, yoga and activities during the day. During the inspection, we observed that people who preferred to remain in their rooms had their television on. People also had individual sessions with staff. One person we observed

was engaged in painting and another person was playing games. We also observed a person in their room and newspapers were available for them as this was something that they enjoyed doing. Staff were also attending to people doing their nails and hair.

We received some positive feedback about the activities. People using the service told us "There are enough activities-singing, exercise and I can join in the prayers. They celebrate the festivals" and "We got enough activities- yoga, exercise." Relatives told us "They have a wheelchair and a walking stick, they try to make [person] walk so they are mobile. There are some Gujarati staff here and [person] can communicate with them. It's like a family here" and "They try to get [person] out to do exercises. The unit manager was receptive when I had to point some things. They wrote it down and appeared willing to change things to things got sorted." However some relatives told us activities were very limited and not mentally or physically stimulating. People were not kept mobile and taken for walk and staff didn't have the time to walk people. The project manager told us they would review the activities programme and we discussed that activities were generic and could be more considerate of people's culture and people's specific needs such as mobility and dementia related activities.

There were procedures for receiving, handling and responding to comments and complaints. There was a complaint policy in place and there was a system for recording complaints. We found although the complaints were responded to we did not see any evidence which showed that they were evaluated and used as an opportunity for learning or improvement for the service. Also specific action plans were not in place to show the action that had been taken to improve areas of the service based on the complaints received. Some relatives told us they did not feel they could raise concerns in the home and felt there would be repercussions if they did. They felt that they had raised issues previously and things were not being resolved. The operations director told us that the interim manager had met with the relatives to work through things they were not happy with and was hoping that things were starting to settle. Care review meetings had started to take place which management felt should address any concerns relatives had about the service.

Requires Improvement

Is the service well-led?

Our findings

We received varied feedback about the way the home was managed. People using the service told us "Everyone is good, manager is good, I am happy here" and "I have no complaints whatsoever. I go straight to management if I have a complaint."

However, some relatives told us they were not happy with the way things were managed in the home. They told us "I am not happy with management", "We have tried to work things through, nothing has happened", "We can't rely on what they say. We feel we don't get anywhere and the trust has gone", "I don't have the confidence to raise any issues", "The things we are telling you now, we have raised with management time and time again and nothing gets done" and "We don't know who the manager is and who has the ability to make decisions."

In June 2016 the registered manager resigned. As a result of this an interim manager was in place to ensure managerial stability in the home until a new registered manager was appointed. A clinical lead was also appointed but they also resigned. A number of care workers that worked for the home had also left since the last inspection. The service employed agency care workers and agency nurses to fill the empty vacancies. During this time, a number of concerns were raised by some relatives about the overall quality of service and care being provided by the home. A whistleblowing concern and a number of safeguarding issues concerning people's care had arisen.

During this inspection, we found the number of agency staff had decreased and permanent staff had been employed to ensure consistency in people's care. The management structure of the home was a team of care workers, nurses, kitchen and domestic staff, admin manager, project manager, interim manager and the provider. The operations director told us they had undergone a major recruitment programme to ensure the home had permanent staff and this was still continuing.

At our inspection on the 19 May 2016, we found systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people. This meant the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider sent us an action plan setting out the actions they would take to meet the regulation. During this inspection we found some action had been taken however there were still areas of improvement needed. We found there was no systematic auditing process in place to effectively identify, monitor and improve the quality of service being provided to people using the service

At the last inspection, we found audits were limited to checks being undertaken and no effective evaluation of the quality of service being provided to people had been conducted. During this inspection we found audits were of a similar nature. When asked to see their audits we were provided with copies of medicines and infection control audits. In these audits set areas were being checked and ticked off with some comments or observations made. However, there were no records as to how the shortfalls were being followed up or rectified. For example, the infection control audit, dated October 2016, was only half

complete. Some deficiencies had been identified, for example a wheelchair was not stored correctly and waste bins required cleaning, but there was no action plan in place to show how these areas were addressed. In the medicines audit completed for September 2016 and October 2016, MAR sheets were not being checked at each shift handover to ensure they have been completed properly. There was no action plan or further comment made to show how this was going to be addressed and by whom.

We asked whether an overall audit had been conducted of the service. We were advised by the project manager that no overall audit had been completed. This meant it was not possible for the provider to obtain an overall view as to the quality of service being provided, identify poor practice and make improvements.

We were provided with a copy of a monthly support visit that had been carried out on the 20 October 2016 by a senior manager of the provider organisation. This visit record covered the physical appearance and presentation of the home, housekeeping standards and dining. The visit record identified areas to be improved in relation to untidy storage areas, maintenance issues in the home and laundry management. The document listed 'advice' as to what should be actioned in the home to address these issues however there no action plan in place to show when these areas were going to be addressed and by whom.

The interim manager showed us an email which summarised the findings of an external audit that has been recently conducted. We were not provided a copy of the report as this has not yet been produced by the external auditors. The areas where improvements were found to be needed included standardisation of paperwork, maintenance of induction records, health and safety checks and audits. However, there was no evidence which showed an action plan in place to address these issues. An example of this would be that we noted this audit also noted a member of staff did not converse with people during breakfast. This was also observed during this inspection in which some care workers were task focused and did not behave appropriately with people using the service during lunch time.

We discussed the audit process currently in place with the project manager and operations director. The operations director told us he would be looking into adopting a more effective audit tool to be implemented as soon as possible. The operations director also told us they wanted things to improve and will continue to work towards achieving this.

During the inspection, we found improvements with the management of medicines, care review meetings had been conducted and action had been taken to recruit permanent staff and the number of agency staff has significantly reduced in the home. However, we still found records were not being completed accurately, there was a lack of constructive communication between relatives and management to be able to resolve issues promptly and constructively. Overall there was no monitoring completed such as spot checks of staff performance, call bell monitoring, night visits and no systematic auditing processes operating effectively to evaluate the quality of service being provided, identify poor practice and drive improvement.

The above demonstrates a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When speaking with staff they expressed confidence in the management of the home and were aware of the homes objectives. They told us "We can approach the project manager and interim manager", "They are listening and things are changing", "We meet every day in the morning and any if we have any concerns we can raise" and "Teamwork is good." Staff also told us "I am aware of the aims and objectives of the service to provide a high quality of care and ensure residents were safe and comfortable". Another care worker told us "We aim to deliver the best possible care in a tender and loving way." The staff spoken to showed awareness of issues facing the home but were very receptive to change and improving things further.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate and contemporaneous records were not being kept or effectively monitored about people's care and support they needed and had received. This would place people at risk of receiving inappropriate care. The current systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people. Regulation 17 (1) (2) (a) (c)