Parcs Healthcare Limited

Gokul Nivas

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 12 October 2015 and was unannounced.

Gokul Nivas is a care home that provides residential care for up to 10 people and specialises in caring for Gujarati Asian Elders whose first language is Gujarati. The accommodation is over two floors, accessible by using the lift and stairs. At the time of our inspection there were seven people in residence and one person was in hospital.

A registered manager was in post. 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.

As part of this inspection we looked at the improvements made by the provider and to confirm that they now met the legal requirements.

People told us they felt safe at the service and with the staff that looked after them. Staff understood the safeguarding procedure (protecting people from abuse) and knew how to keep people safe.

Summary of findings

People's care needs were assessed including risks to their health and safety when they started to use the service. However, improvements were needed in relation to how risks to people's health and wellbeing were assessed, monitored and reviewed. Care plans were not reflective of people's current needs, which meant people may receive unsafe or inappropriate care.

The systems to store, manage and administer medicines safely were not followed correctly. Further action was needed to ensure the national guidance was followed in relation to safer management and administration of people's medicines.

Staff were recruited in accordance with the provider's recruitment procedures. Further action was needed to ensure there were sufficient numbers of staff available to meet people's needs safely and reliably.

Staff received an induction when they commenced work and on-going training to support people safely. We saw staff used equipment to support people correctly. Staff received support through meetings and staff appraisals. Staff would benefit from training and support to understand the needs of people living with dementia and how to support them practically so that their wellbeing is promoted.

We found the requirements to protect people under the Mental Capacity Act and Deprivation of Liberty Safeguards had not been followed. Further action was needed to ensure a mental capacity assessment was carried out to so that people's wishes were known and kept under review. Where a person lacked capacity to make decisions or were unable to do so, the provider had not acted in accordance with their legal responsibilities to ensure that any best interest decisions made involved the relevant people and health care professionals.

People were provided with a choice of meals that met their cultural and dietary needs. People had access to health support and referrals were made to relevant health care professionals where there were concerns about people's health.

People told us that they were treated with care and that staff were helpful. We observed staff respected people's dignity when they needed assistance.

There were limited planned activities which people could take part in. People were supported to observe their faith.

People did not consistently receive care that was person centred and the care plans did not reflect their wishes and preferences. Staff had some knowledge of people's life history and what was of interest to them despite the lack of information in the care records. Further action was needed to ensure people were at the centre of their care; ensure staff were available and systems were in place to ensure people experienced tailored care and support as outlined in the provider's aims of the service provided.

People were confident to raise any issues, concerns or to make complaints. However, we found that concerns raised were not always addressed. Although there were regular meetings held for people who used the service, the issues raised were not always addressed.

The provider's quality governance and assurance systems were fragmented. There were limited audits carried out and those too were ineffective. There was no evidence to demonstrate that the provider reviewed, identified shortfalls and took steps to make improvements.

There was a registered manager in post. However, they were not in day to day charge of the service because they were managing services outside of this area. We found the service was managed by the registered manager and supported by staff from the service next door, which is a service for the same provider.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

People told us they felt safe. Staff had an understanding of what abuse was and their responsibilities to act on concerns.

Risks to people's health and wellbeing was not properly assessed, managed or monitored. The management of people's medicines were not always done safely or correctly, which could affect people's health.

Safe staff recruitment procedures were followed. Improvements were needed to ensure there were enough staff available to safely support people and meet their needs.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were cared for by staff that had received an induction, training and supported. Staff would benefit for further training to support people living with dementia.

The care and treatment people received was not always effective because the requirements under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were not followed to ensure people's legal rights were respected.

People's nutritional needs were met. People were referred to the relevant health care professionals to promote their health and wellbeing.

Is the service caring?

Good

The service was caring.

People were treated with kindness, their privacy and dignity was respected.

People made choices about their daily care and support needs. Staff respected people's choices and lifestyle.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's needs were assessed when they first started to use the service but the care records did not reflect individual wishes, preferences and interests. People did not receive personalised care and support that was centred on their needs and timely. People, their relatives, staff and health care professionals were not involved in the review of their care needs.

Summary of findings

People felt confident to make a complaint. Better recording of complaints and actions taken would demonstrate that the complaints procedure was followed.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

There was a registered manager in post but did not manage the service on a daily basis.

The provider encouraged feedback from people who used the service, their relatives and staff. There was little evidence of the improvements made as result of the feedback because no one from the management team took responsibility to monitor and bring about change.

The provider's quality assurance and governance systems were not robust. Improvements were limited because no one from the management team took responsibility to assess, analyse, identify or develop action plans to make improvements.

Gokul Nivas

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 October 2015 and was unannounced. The inspection was carried out by two inspectors. One inspector spoke with people in their first language, which was not English.

Before the inspection we looked at the information we held about the service, which included information of concern received and 'notifications'. Notifications are changes, events or incidents that the provider must tell us about. We also looked at other information sent to us from people who used the service, relatives of people who used the service and health and social care professionals.

We spoke with six people who used the service and two visiting relatives. We also spoke with one visiting health care professionals.

We spoke with the manager who was the registered manager of the service next door, which is part of the same provider group. We spoke with four staff involved in the care provided to people. Those included senior and three care staff. We also spoke with the cook and the handy person.

We looked at the records of six people, which included their risk assessments, care plans and medicine records. We also looked at the recruitment files of three members of staff, a range of policies and procedures, maintenance records for the equipment and the building, audits, complaints and the minutes of meetings.

We contacted health care professionals and commissioners for health and social care, responsible for funding some of the people that live at the home and asked them for their views about the service.

Requires improvement

Is the service safe?

Our findings

At our inspection of 4 July 2014 we found suitable arrangements were not in place to safeguard people who used the service against the risk of harm or abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that the action had been taken. Staff we spoke with knew how to keep people safe. The staff training records showed that staff were trained in the safeguarding procedures as part of their induction. We saw that incidents and accident, which affected the health or safety of people recorded and action had been taken.

People told us that they felt safe with the care provided and the staff that looked after them. Relatives we spoke felt their family member was safe. One relative said, "I know my mother is safe here, otherwise she would tell them [management and staff] and me."

We looked at how the provider protected people and kept them safe. The provider's policy and procedure had guidance for staff as to what they should do if they were concerned about the welfare of anyone who used the service.

Prior to our inspection visit we asked the local authority responsible for the funding of some people who used the service. They told us they had investigated a concern which the provider later reported to us that an incident had occurred. The local authority had worked with the provider and ensured the service was safe for the people who resided there. That showed people could be confident that their safety and wellbeing was protected.

A relative told us that risk to their family member's health had been assessed and measures to manage those risks had been agreed.

People's care records showed risk assessments were completed. Those related to people at risk of falling when walking or moving around, moving and handling for people who were unable to walk independently or need support to move safely and risk of developing pressure sore. Where appropriate, the equipment to be used was listed in the care records. However, there was no information as when the person was assessed as needing a hoist and that being most appropriate option used to promote the person's independence.

Risk assessments completed had limited information and did not focus on the needs of the individual such as sitting to standing and getting in and out of bed. For example, bed rails are one option to prevent people from falling out of bed were used in some bedrooms. However, the use was not supported by any form of assessment and the care plans did not show the purpose of the bed rail and what measures had been taken to reduce the risks associated with the use of bed rails, such as entrapment. Risk assessments did not take account of individual factors such as people's ability to understand and any visual impairment, which affect people's safety and independence. That meant staff were not always made aware of how to ensure risks to that person was minimised.

People's care plans did not promote positive risk taking. There was limited evidence that people were continuously involved in the planning of their care to maintain their safety. Being independent was regularly referred to as a key outcome within care plans for people and yet there was no guidance for staff to follow on how independence could be achieved or maintained. For example, one person's care plan stated that the person was unable to do anything for themselves, then later stated 'enable them to do as much as possible for themselves' but does not state how, in what way or what level of assistance is needed.

The manager told us they regularly reviewed people's care plans and risk assessments. There was no evidence of what information was looked at as part of the review and who was involved. For instance, the impact of any changes to people's medicines, and the involvement of the person, their relative and staff. We found that any changes to people's needs were not recorded. This was the case for one person who told us that they needed more supported due to changes in their health and medicines. That meant people's health and wellbeing could be at risk because assessments of people's health, the guidance for staff in delivering the care safely and the person's involvement in planning and systems to review of their care was not robust.

This was a breach of Regulation 12 (1) (2) (a) (b) under the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Requires improvement

Is the service safe?

We asked people for their views as to whether there were sufficient staff to meet their needs. People told us that they regularly had to wait to be assisted because staff were busy helping other people. One person told us that they chose to wake up at 6am so that the night staff could support them at a pace that suited them. Relatives told us that whilst at a staff member was around they were often focussed to tasks to be done and they relied on the staff from the service next door to assist people.

We found sufficient numbers of staff were not always available to meet people's needs when assistance was needed and to keep them safe. The manager told us that the staffing levels were based on one member of staff to five people, with additional support from a 'floating' member of staff who worked between the two services. It was not clear from speaking with the manager how the staffing levels were determined. For instance, we found that four people who used the service now required a hoist for all transfers, which meant two staff were needed to use the equipment safely. Therefore, when one or more people needed the support of two staff at the same time, someone would have to wait and potentially their dignity could be compromised because staff were not available.

The manager told us that there was one waking night staff. A 'walkie-talkie' was provided so that staff could request assistance from the service next door. However, support was not always provided in a timely manner if they were supporting people at the service next door.

Staff told us that shifts can be 'very busy'. They said even though they could request assistance from the service next door, they felt sometimes people had to wait a long time for assistance when they needed it quickly. Staff felt that they did not have time for a rest break and that breaks tended to be 'snatched moments'. We observed this to be the case as a member of staff on their break was interrupted several times by relatives and people requiring assistance. Staff told us that the night staff assisted between four to five people to get up from 6am onwards. The daily care record and night care logs we looked at showed that the waking night staff were required to attend to multiple calls for transfers and personal care during the night. That meant people's needs were not consistently met because staff were not available to help people in a timely manner.

This was a breach Regulation 18(1) under the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's safety was supported by the provider's recruitment practices. Staff records we looked at confirmed that relevant checks had been completed before staff worked unsupervised, which included a check with the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions and ensure that staff employed are of good character.

We found medicines kept in the fridge were regularly checked and stored within the recommended temperatures. However, this was not the case for all medicines. Some prescribed creams were left in a communal bathroom, which people used regularly. People could be at risk if they used the prescribed creams by accident. These items were removed when we told the manager.

We found several prescribed medicines in bottles and topical creams that were not dated when opened, this is important because those only have a limited shelf life. Because staff could not identify when the medicine had been opened it meant people were at risk of receiving medicines that may not be within the recommended expiry date. That medicines people could not be assured that their medicines was kept securely or appropriately stored.

We found accurate records were not kept of the medicines in stock including any medicines carried over from the previous month. We saw that where topical medicines were prescribed, the medicine care plan did not have a body map or instructions on the medicines administration records to show the areas where the topical medicine should be applied. There were no photographs of people found on the medicine administration record or the blister packs. This is important information to ensure that staff who did not regularly work in the service gave people their right medicines.

The providers' medicines management procedure was up to date. Staff told us one person had their medicines disguised in food and drink, otherwise known as covert administration. A GP had authorised the use of this in writing. However, there were no care plans or other instructions to show how staff could administer covert medicines safely. There was no evidence that advice had been sought from the pharmacist about the type of food and drink medicines could be mixed in. We found no evidence that a mental capacity assessment had been completed with regards to the administration of covert medicines.

Requires improvement

Is the service safe?

We saw that some people had additional medicines that were not prescribed, known as homely remedies. These included oral and topical herbal medicines. These herbal remedies were not included in the medicine care plan and there were no protocols in place to support people to safely self-administer. That meant people were not consistently protected by safe systems for managing their medicines.

This was a breach of Regulation 12 (2) (g) under the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We observed a staff member administering medicines to a person at lunchtime. They followed safe procedures and completed the medicine administration records charts once the person had taken the medicine. We observed them talking to the person and being patient to make sure that the person had taken the medicine. Staff we spoke with told us that that staff had been trained to give medicines and their training records viewed confirmed this.

Requires improvement

Is the service effective?

Our findings

At our inspection of 4 July 2014 we found that staff were not trained and did not receive training updates to ensure they had the skills, knowledge and expertise to meet people's needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that staff had received the training to meet the needs of people who used the service. Staff told us they undertook a range of training in general care, health and safety. These were recorded on the staff training matrix and updated as necessary. We spoke with one of the newest members of staff. They told us they had completed an initial three day induction prior to starting and were now working alongside senior staff. That enabled staff to spend time with experienced staff to enable them to provide effective care and support.

All new staff were required to complete an induction using a combination of video tutorials and shadow shifts where they worked alongside experienced staff. There was a programme of training for staff to complete. Staff were trained to use equipment correctly and safely. During our inspection visit we observed two staff safely transfer a person from a chair to a wheelchair. Staff followed safe practice and communicated with the person throughout the transfer. The service currently uses a combination of face to face and e-learning but the training records did not accurately reflect the most recent date of the training completed. When we shared with the manager they assured staff training records would be updated.

We found staff knowledge and understanding of caring for people living with dementia varied. Records showed that some staff had completed a basic awareness level of training. However, when we asked staff how they would support a person living with dementia who was becoming distressed or anxious, their responses were very different, neither of which were in line with best practice guidelines. It was evident that staff did not understand how to support people living with dementia and they consistently referred to a person living with dementia as 'not having capacity'. That meant people's liberty and rights may not always respected by staff.

People told us that staff knew how to support them and meet their needs. One person told us that staff walked with them as they used a walking frame, which they felt was reassuring. Another person told us that staff took care to make sure there were no obstructions and would lift their dress off the floor so they did not trip over their clothing when they walked.

Staff felt supported through the regular staff meetings, supervisions and appraisals. Staff found meetings were informative. Records showed that issues raised about staff's practice were discussed in their supervision but no reference as to what steps were taken to support staff with any additional training or how this development need was followed up in the next supervision. There was no evidence that the impact of these training methods had been evaluated and the staff member's knowledge assessed against their role.

The minutes of the staff meeting showed issues discussed such as peoples' care, improvements to care such as reminding staff to check pressure areas during personal care, communicate with each other during hoist transfers and ensuring hoists were charged. We saw that the same subjects were discussed at subsequent meetings which showed that there were continued concerns in some areas of care which did not appear to be resolved over time.

We shared our findings with the manager who assured us that staff supervisions and meeting would be used more effectively to assess staff's knowledge and how the learning had been put into practice.

At our inspection of 4 July 2014 we found suitable arrangements were not in place to obtain people's consent and protect them from undue restrictions. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements, which included further training for staff with regards to consent and ensure staff liaise with health care professionals when people ability to make decisions about their care and support is an issue.

Requires improvement

Is the service effective?

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.

At this inspection we found there were limited improvements. People told us that staff always sought consent before they were helped and we observed this to be the case throughout our inspection visit. However, we found that the correct procedure under the MCA had not been followed for people who were unable to make decisions or give consent about their care and treatment.

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, whereby an application for a Deprivation of Liberty Safeguards (DoLS) is submitted to the Supervisory Body. We checked people's care records and found that the mental capacity assessments were ineffective. There were general statements recorded that the service user 'did not understand.' The forms did not detail the level of support the person needed to make a decision on a day to day basis and did not relate to any specific decisions made at any specified time.

A person's care plan identified that they needed two staff for all transfers as a hoist needed to be used. There was no evidence of any referral to a professional medical, such as occupational therapy or physiotherapy, or their assessment to support this decision. The manager told us that were trained to assess risks and therefore, had made the decision that the person needed a hoist for all transfers because they felt that the person did not have capacity to give consent to this. There was no evidence that the least restrictive option had been considered as part of a best interest assessment. That meant people could have their liberty deprived.

We also found that there were no health decision specific mental capacity assessments carried out for a person who had their medicines given to them disguised in food and drink. Staff told us that the person did not know their medicine was disguised in their food. The procedure to make best interest decisions was not followed and care plans not reflective of how the person needed to be supported. That meant people's human rights were not respected and best interest decisions made may not be appropriate.

This was a continued breach of Regulation 11 under the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us that they enjoyed the meals provided. People said the meals were good, choice and dietary needs met. One person told us that they celebrated their birthday and had their favourite dishes prepared and brought in. People told us that the menus were discussed at the residents meetings and they had special dishes prepared on days when religious events were celebrated.

Throughout the day we saw people were offered regular drinks and snacks. All the meals were Gujarati vegetarian meals and served in a thali (plate with compartments). Lunch was the main meal of the day which consisted of three main curries; served with rice and roti (flat bread) and condiments, such as yoghurt, pickle, poppadum and a portion of fruit. The meals were freshly prepared by the kitchen staff for both services.

Staff told us that they supported two people to eat their meals. Staff monitored people's appetite and would inform the manager if they had any concerns.

Records showed that an assessment of people's nutritional needs and plan of care was completed which took account of their dietary needs. People's weights were measured and where concerns about people's food or fluid intake had been identified, they were referred to their GP. At the time of our inspection visit no one was under the care of the dietician. The information in the care plans varied about people's dietary needs, the assistance needed or any specialist equipment required. For instance, one person's care plan identified that they needed help to eat and drink and another required meals suitable to manage their health condition, such as diabetes. There was no information as to the role of staff in supporting people to maintain their health. We shared this with the manager who assured us that they would review and update the care plans.

People told us their health and medical needs were met. People could see the GP who visited the service twice a week. One person told us that a nurse visited them regularly to help meet their specific health needs. People's

Requires improvement

Is the service effective?

care records showed that they received health care support from health care professionals, such as doctors, nurses and also attended medical appointments. That showed people health and wellbeing was maintained.

Relatives were satisfied that their family member's health needs were supported and where agreed, were kept informed about any health concerns.

Health care professionals spoke with during the visit told us that staff were knowledgeable about the care needs of the people they supported. They felt staff sought advice in a timely manner and followed the guidance provided to meet people's needs.

Good

Is the service caring?

Our findings

At our inspection of 4 July 2014 we found that people were not always treated with respect. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found people were treated with respect when supporting them with their meals and personal care needs. We saw that staff spoke with people before providing support to them, consulting them as to what they wanted to do and if they were ready for support. We also saw staff spoke with people after support was given to check they were happy. We observed shared humour and conversations between people and staff. There was some evidence in care plans that staff were in contact with people's relatives to update them on any care and welfare issues.

We asked people how they were involved in decisions made about their care and how they wished to be supported. People told us they were asked what support they needed when they first started to use the service. This was the case for someone that had moved to the service recently. They told staff that they preferred to have a shower every day after breakfast and that staff supported them as per their wishes. Their care plan also confirmed this to be the case. We saw that people were dressed in clean clothes of their choosing. One person said they preferred to wear a kaftan, which was comfortable for them. That showed people made decisions about their presentation which was important to them.

Relatives told us that they were involved in the initial care planning process for their family member and had had some discussion with staff when their family member's needs had changed. One relative had not seen the updated care plan and were planning to ask staff about their family member's updated care plan.

People's records we looked at had information about how they wished to be cared for. Their individual choices, preferences and the decisions made were recorded but not reflected in the care plans. Care plans were available to staff but they did not read them. Despite care plans not being reflective of how people liked to be supported and their preferences, staff knew people's individual preferences. The daily records completed by staff included information about each person's day such as their involvement in activities and contact with other people such as relatives, friends or professionals.

People told us that staff were caring and that they treated them like their own 'daughters', which is a way of showing an affectionate relationship. Everyone said that staff were caring and kind. People had developed positive and trusting relationships with the staff and were confident to ask for help when staff were available. People told us that staff treated them with respect and maintained their privacy and dignity.

Staff spoke in people's first language, which was Gujarati, as Gokul Nivas is a home for Gujarati Asian Elders. One staff member told us that they learnt to speak Gujarati so that they could converse with people effectively. We saw staff's approach to people was caring and spoke with people politely using a soft tone. For instance, staff took care when they supported people to walk to the bathroom or to their room and gave clear directions.

We saw relatives visiting their family members were also treated with care and compassion by the staff. Relatives spoke positively about the staff with regards to the care provided and felt their family members were treated in a respectful manner and one said, "Carers are lovely and considerate."

Health care professionals spoken with during the visit told us that they found staff to be caring, kind and knew the needs of people they looked after. They commented that staff were always respectful of people's privacy and dignity irrespective of the person's physical or mental wellbeing.

People felt staff treated them with respect and their dignity was maintained. People's bedrooms were respected as their own space. We saw that staff always knocked and did not enter until asked to do so. All the bedrooms had an ensuite wash hand basin and toilet which promoted people's privacy. The bedrooms we saw looked comfortable and were personalised to reflect individual taste and interests.

Good

Is the service caring?

At meal time staff supported people to eat their meal in a sensitive and responsive manner. The staff took care to ensure the person's dignity was maintained. For example, people were provided with an apron to protect their clothing.

Staff we spoke with understood the importance of respecting and promoting people's privacy and took care when they supported people. Staff described ways in which they preserved people's privacy and dignity. During our inspection we observed that staff attended discreetly to people's on-going personal care needs to help ensure they remained clean and comfortable. We saw staff took steps by using a privacy screen when a health care professional was treating a person in the lounge. This was a further example that demonstrated people's privacy and dignity had been maintained in a communal area.

Requires improvement

Is the service responsive?

Our findings

At our inspection of 4 July 2014 we found that people were not supported to express their views with regards to raising concerns. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements. That included the installation of a suggestion box and opportunity for people to express their views and concerns at the meetings held for them.

At this inspection we some improvements were made. We saw a 'suggestion / comments' box was installed by the entrance to the service. The manager told us they checked the box regularly but had not received any comments. The complaints procedure was also translated into Gujarati, to help people who used the service understand the process and the action that the provider would take to address the complaint.

People told us that they were happy with the care they received and had no complaints. One person told us that they if they had any concerns they may speak with staff on duty. Relatives told us that any concerns they had about the care of their family member was raised with the staff on duty if the manager was not available. Relatives said issues raised with staff were usually addressed. Relatives told us that when meetings were held to discuss the issues they did not always receive anything in writing as to the actions agreed to address the issue.

The provider had a system in place to record complaints received but this was not robust as there were two files were kept for complaints. One complaint file showed the provider had not received any new complaints since our last inspection of the service. However, the 'incidents and complaining file' had record of complaints and concerns received from people who used the service and relatives. There was no evidence that neither the manager nor the provider had reviewed the concerns logged, investigated or taken any action. We raised this with the manager who assured us that only one complaint file would be maintained and a record would be kept of any verbal complaints received and the action taken.

The manager told us that regular meetings were held with the people who used the service and their relatives. These meetings provided people with an opportunity to share their views about the menu and social activities and outings. The meeting minutes showed people were happy with choice of meals and suggested outings were discussed. At the meeting in August 2015 people and their relatives were consulted about the installation of CCTV in the lounge. However, there was no record of what action the provider and manager were to take in response to the issues raised. Previous meeting minutes showed similar issues about activities had been raised but those were not always reviewed and no record of improvements made as a result of suggestions made by people. Therefore, meetings were not an effective form of communication as issues raised were not always acted upon or followed through by the provider for example activities and social outings. We shared our findings with the manager who assured us action would be taken to address the issues found.

We found there was a lack of consistency in the quality of care and support provided to meet people's individual needs. Staff were aware of people's needs but could not always respond in good time. This was made worse because the service did not always have sufficient numbers of staff available to meet people's needs, especially at busy times when people often had to wait for staff from the service next door to help. Staff told us the people's needs had increased in relation to their personal care needs and to promote their dignity. However, this change was not known by the manager because they did not always check with staff whether people's needs had changed, hence not taken into account when reviewing the staffing levels to ensure it was appropriate.

People experiences shared with us and our observations of a number of instances showed that care provided was not focused on the needs of people. Staff we spoke with also acknowledged that due to staffing levels people often had to wait. Several people told us that they were supported to get up by the night staff including one person who chose to get up about 6am in order for them to have the support they needed to manage their personal hygiene. Another person told us that they were supposed to use the foot massager daily but that had not always happened if staff were busy. Furthermore we were told that the foot massager was not working properly hence the handy person was trying to fix it.

Requires improvement

Is the service responsive?

The provider's statement of purpose, which is document that gives information about the range of services and refers to care provided as being 'person-centred'. However, we found this was not the case. Care plans were not personalised to ensure people's individual identified needs were met and did not have sufficient information for staff about how to respond to signs of confusion, disorientation and distress associated with people's diagnosis of dementia. Information gathered at the point of admission was not taken into account in the planning of people's care such as life history, what and who is important to the person, likes and dislikes; wishes, interests and aspirations. For instance, information about people's favourite meals could be used in the planning of menus but this was not the case. Peoples care plans focused on their needs and difficulties and did not reflect on their ability, interests or personalities.

We observed staff cancelled the call bell twice in the office without checking on the person. We went to see the person who was in some discomfort told us no one had been to check on them. There were two staff on the first floor but they were busy supporting a person using a hoist, so we asked the senior member of staff to assist them. This was another example to demonstrate the care provided was task focused instead of person centred because sufficient numbers of staff were not available to support people.

Staff told us they learnt about the help people needed and what was important to them when they started to support people. Care plans were available but those had little information about how people wished to be supported, what they liked around them or the level of assistance needed to help maintain their independence. Staff found the handover meetings were informative about people's needs but not how they wished to be supported. The daily records completed by staff detailed the personal care assistance each person had received but made no reference to how any health issues could affect how staff supported them. For example, a person was assessed as having sight loss but their care plan made no reference to the specific needs of that person relating to their visual impairment. This further supported what relatives had told us. That meant people did not receive person centred care because staff were not always responsive to their needs and their knowledge varied about the level of support people needed.

The manager told us that they were in the process of introducing person centred information called a 'Life Story' and had started to collate information for each person which included life history and likes and dislikes. We only saw the drafts as these were yet to be included in people's care plans.

There was no formal record of the review of people's care and what if any changes were agreed. People had not been involved in the review of their care in a meaningful way nor were their views sought about the care provided. The manager told us they reviewed the care plans independent of the person, staff or any other information recorded by staff in the care records. If the daily records had been reviewed by the manager then they would have found concerns recorded by staff that needed to be investigated.

People who used the service and visiting relatives told us there were not enough activities for people, especially for people with a visual impairment. We found two sets of activity records, one listed activities such as bhajan (religious songs), reminiscence and bingo took place and another listed activities such as yoga, hand massage and gardening. A third record listing activities people took part in which was found within the 'residents meeting' minutes. There was a list of trips for up to six people who regularly visited the local temple (place of worship). It was not clear which record was accurate because the information differed in all three records. Furthermore, we saw very few activities were recorded for afternoons or evening.

We saw people spent most of their time sitting in the lounge area. The television was continuously on at one end of the room in the lounge making it difficult for people to see or hear it. We saw that most people left the lounge after lunch and were assisted to their rooms for a 'lie down'. One person told us that preferred to have a nap in the afternoon because they got up at 6am every day. Staff told us that this was usual practice in line with each person's choice and preference, but we could not find reference to this within the care plans or pressure relief assessments. That meant people could not be confident they received personalised care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the service was quick to respond when people were not well, acting on behaviours that were not usual

Requires improvement

Is the service responsive?

and seeking appropriate medical assistance.Relatives told us that after they sought advice from an organisation that specialises in supporting people with visual impairment the provider improved the lighting in the person's room.

Requires improvement

Is the service well-led?

Our findings

At our inspection of 4 July 2014 we found that the provider did not have effective systems in place to assess and manage risk to people's safety and wellbeing, and to monitor the quality of service provision. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan outlining how they would make improvements, which included better recording and reporting of incidents and to gather people's views about the service.

At this inspection we found the improvements made were not consistent with action plan. People's care, safety and wellbeing was not effectively monitored because people were not involved in the review of their care. People's care plans were not person centred or reflective of their current care and support needs or their individual lifestyle choices. The manager had signed to confirm people's care plan and risk assessment had been reviewed but there was little evidence to show who was involved and what other information was taken into account. If the daily records had been reviewed by the manager then they would have found concerns recorded by staff that needed to be investigated. Without up to date knowledge and assessment of people's daily care and support needs, the provider cannot effectively determine and plan the number of staff required to ensure the needs of people and the service continue to be well managed.

Surveys were carried out to gather people's views about the quality of care provided in February 2015. The completed surveys were kept in a file. However, no one had analysed the results or developed an action plan to address any issues. There was no evidence to show how those results were shared with the people who used the service and their relatives.

We found that meetings were held with people who used the service and relatives. However, the meeting minutes showed where issues had been raised there was no record of the how those had been actioned or reviewed through the provider's quality assurance system. Similarly, the staff meetings were used as a source of information between management and staff. The minutes showed there was no facility to review actions from the last meetings, such as training and staffing levels. There was little evidence of how previous issues raised had been addressed or any discussions about the improvements planned for the service.

Staff told us that the manager would inform people about any changes in practices. When we asked them what they would do in emergencies, they told us everything was referred to the manager or the person in charge. We found the manager had some knowledge about the new regulations but did not understand the principles of good quality assurance systems or the importance of accessing information from experts and other agencies to drive improvements. For instance, although the provider policy and procedure was up to date in relation to the administration of covert medicines, the practice was not consistent with the procedure. That meant the provider's system to ensure the information and guidance communicated to staff was not robust.

The provider's quality assurance systems continued to be fragmented. The manager did not demonstrate a good understanding of a quality assurance system. They were unable to provide evidence of any effective and comprehensive in-house monitoring system which highlighted the key risks to the delivery of service at Gokul Nivas and how these were managed. Clear and accurate records were not kept to enable the provider to monitor the delivery of care. For example, the manager carried out weekly medicines audits by signing the medication administration record. There was no evidence of what the audit covered, the standards that they had audited against and any remedial action. That meant the service was unable to provide evidence of any robust checks of medicines and records and supported our findings that the management of medicines was unsafe. We found files with copies of accident forms but no one had an overview of how many falls there had been in a month and actions taken to minimise further falls from happening. The provider had not analysed the incidents, accidents and falls recorded in order to identify any trends or patterns to ensure people's safety could be maintained in the future.

There were systems in place for the maintenance of the building. However, records showed that equipment checked such as bedrails consisted of a tick box in the persons care plan. There was one entry in a care plan

Requires improvement

Is the service well-led?

where a hydraulic bed had broken and referred to another external contractor. But the record did not show when the repair was carried out and what interim measures had been put in place to protect the person using the bed.

The service had a registered manager in post. However, they were not at the service on a day to day basis. The service was managed by the senior staff and the registered manager of the service next door, which is part of the same provider. The manager told us they would be supported by the provider by telephone should it be required. However, it was evident that service was not well managed and reliant on the staff and management support from the service next door. That meant people using the service could not be confident that the service was adequately managed to ensure their safety was protected.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health care professional told us that they spoke with the senior staff in charge and found staff were responsive to people's needs and acted upon instructions and guidance provided.

Prior to our inspection visit we contacted the local authority responsible for the service they commissioned on behalf of some people who lived at Gokul Nivas and asked for their views about the service. They told us that a further contract monitoring visit was scheduled to assure themselves the people that they supported received quality care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1)(2)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment Providing care and treatment in a safe way. Assessing the risks to health and safety of people receiving care or treatment. The provider did not assess risk, monitor, and review the needs of people to ensure that the care provided was safe and new needs could be met. Care plans lacked guidance for staff to follow.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing Providing sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. The provider did not have a robust system to ensure there were sufficient numbers of staff deployed to meet the needs of people receiving care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (g) HSCA 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (3) HSCA 2008 (Regulated Activities) Regulations 2014. Person-Centred Care The care and treatment of service users must be appropriate, meet their needs and reflect their preferences. Carry out an assessment of the needs and preferences for care and treatment collaboratively with the relevant person and/or others. Assessment of people's needs and care plans were not person centred or reviewed regularly with the person or took account of other information including staff and health care professionals. Safe care and treatment Medicines were not managed and administered correctly to make sure people received their prescribed medicines safely.