Diwali Ltd

Diwali Nivas

Inspection report

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Date of inspection visit: 28 April 2015
Date of publication: 02/03/2016

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?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 28 April 2015 and was unannounced.

Diwali Nivas is a care home that provides residential care for up to 16 Asian elders who may in addition experience dementia or a mental health condition. The home specialises in caring for older people including those with physical disabilities, people living with dementia or those who require end of life care. At the time of our inspection there were 15 people in residence.

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. The registered provider was also the registered manager at this service.

People were happy and told us that they felt safe. Staff were able to explain how they kept people safe from abuse, and knew what external assistance there was to follow up and report suspected abuse. Staff were knowledgeable about their responsibilities and trained to look after people and protect them from harm and abuse.

Summary of findings

There was an on-going refurbishment in the home which restricted the space the dining room and lounges. We spoke with people and their relatives, who understood the current situation was for a limited time.

Staff did not always communicate people's dietary needs properly, which allowed people to be at risk of choking. People's care and support needs had been assessed and were involved in the development of their plan of care. People told us they were satisfied with the care provided.

Staff were recruited in accordance with the provider's recruitment procedures that ensured staff were qualified and suitable to work at the home. We observed there to be sufficient staff available to meet people's needs and worked in a co-ordinated manner.

Most medicines were stored safely, however some creams were stored in bedroom areas. These were not locked away, so open to anyone entering the room. We found a number of these were not dated on being opened, so we could not tell how long they had been in use, and assess if they remained active. There were also a number of these that had the label obscured, so again we could not ascertain if they were prescribed for a particular person, or how often they should be applied. People received their tablet, capsule and liquid medication as prescribed. Staff were trained in medicines management and their competency assessed to ensure people's medicines were managed properly. Staff failed to see the significance of medicines stored in bedrooms that may not have been appropriate for the person residing there.

We found a number of infection control issues in the ground floor shower rooms, bedrooms and kitchen area. The staff had cleaning schedules in place. These described which areas were to be cleaned on any given day, as bedrooms were 'deep' cleaned on a rotational basis. There was also a policy and procedure for infection control, and staff had access to these documents. We found that staff did not have a working knowledge of either document, which meant that areas were not cleaned or disinfected in line with the policy.

Staff received an appropriate induction and on-going training for their job role, and all could speak a range of English and Asian languages. Staff had access to people's care records and were knowledgeable about people's needs that were important to them.

The management team and staff knew how to protect people under the Mental Capacity Act, 2005 and the Deprivation of Liberty Safeguard (DoLS). We observed that staff gained consent before care and support was provided. Staff followed the principles of the MCA Code of Practice which promoted people's rights and choices about their care and treatment.

People were provided with a choice of meals that met people's cultural and dietary needs. There were drinks and snacks available throughout the day and night. We saw staff supported people in their bedrooms who needed help to eat and drink in a sensitive manner. The catering staff were provided with up to date information about people's dietary needs but not people's special requirements. We found there was a lack of communication between the cook and care staff for people who had their food blended. Peoples' food was blended to aid the persons swallowing where they had been assessed as having swallowing difficulties by a health professional.

People felt staff were kind and caring, and their privacy and dignity was respected in the delivery of care and their choice of lifestyle. Relatives we spoke with were also complimentary about the staff and the care offered to their relatives.

We observed staff speak to, and assist people in a kind, caring and compassionate way, and people told us that care workers were polite, respectful and protected their privacy. We saw that people's dignity and privacy was respected which promoted their wellbeing.

Staff had a good understanding of people's care and cultural needs. People told us that they had developed good relationships with staff and were enabled to speak with them using their first language.

People are involved in the review of their care plan, and those that are not are happy for their relatives to be involved. We observed staff offered people everyday choices and respected their decisions. Staff spoke clearly to people, and explained what they were doing and where appropriate in the persons first language.

Some people chose to be involved with activities such as painting, puzzles, arts & crafts and finger nail painting. We saw a member of staff who was providing hand massages

Summary of findings

for people. We also spoke with a beautician who told us they attend the home once a month if anyone requests reflexology. That meant the staff consider people's wellbeing.

People told us that they were able to pursue their hobbies and interests that was important to them. These included the opportunity to maintain contact with family and friends as visitors were welcome without undue restrictions. People were also able to have their cultural and religious needs recognised, for some this meant being dressed in culturally appropriate clothes and for others having their religious needs met. This protected people from social isolation.

Staff told us they had access to information about people's care and support needs and what was important to people. Care staff were supported and trained to ensure their knowledge, skills and practice in the delivery of care was kept up to date. Staff knew they could make comments or raise concerns with the management team about the way the service was run and knew it would be acted on.

The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service, their relatives and health and social care professionals.

Staff sought appropriate medical advice and support from health care professionals. Care plans included the changes to peoples care and treatment, and people attended routine health checks.

People were confident to raise any issues, concerns or to make complaints. People said they felt staff listened to them and responded promptly.

People who used the service and their visiting relatives spoke positively about the open culture and communication with the staff. We noted that the provider interacted politely with people and they responded well to him. When we spoke to the provider, it was clear he knew people and their relatives, by the way in which they conversed.

The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours. However on the day we visited the staff rota had not been updated to reflect the changes to the staff on duty. That meant that the record had not been maintained properly in line with current legislation and guidance, and was not a true reflection of staffing on the day.

The provider understood their responsibilities and displayed a commitment to providing quality care through employing staff that were culturally appropriate. Care staff understood their roles and responsibilities and knew how to access support. Staff had access to people's care plans and received regular updates about people's care needs.

There were effective systems in place for monitoring of the building and equipment which meant people lived in an environment which was regularly maintained. However the internal audits and monitoring of the environment, and monitoring and consistency of people's special dietary needs did not provide people with safety. Staff were aware of the reporting procedure for faults and repairs and had access to external contractors for maintenance and to manage any emergency repairs.

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?
The service was not consistently safe.

People were happy and told us that they felt safe.

Medicines in bedrooms were not stored safely.

There was enough staff on duty to keep people safe and meet their needs.

We found a number of infection control issues throughout the home.

Requires improvement

Is the service effective?
The service was not consistently effective.

Staff received on-going training for their job role, and all could communicate with the service user group in their own language.

People were provided with a choice of meals that met people's cultural and dietary needs.

Staff did not communicate people's specific dietary needs appropriately.

Staff sought appropriate medical advice and support from health care professionals

Requires improvement

Is the service caring?
The service was caring.

People felt staff were kind and caring, and their privacy and dignity was respected in the delivery of care.

Staff had a good understanding of people's care and cultural needs.

Staff offered people choices, spoke clearly to people in the person's first language and respected their decisions.

Good

Is the service responsive?
The service was responsive.

People had the opportunity to maintain contact with family and friends.

People were also able to have their cultural and religious needs recognised, and were enabled to dress in culturally appropriate clothes and had their religious needs met.

People had the opportunity to express their views about the service.

Good

Is the service well-led?
The service was not consistently well led.

Requires improvement

Summary of findings

People were positive about the open culture and communication with the staff.

The staff rota did not reflect the staffing in the home.

The internal audits and monitoring of the environment were not effective in picking up areas of concern.

Diwali Nivas

Detailed findings

Background to this inspection

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

This inspection took place on 28 April 2015 and was unannounced.

The inspection team consisted of two inspectors, and an expert-by-experience that was fluent in Asian languages. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience has experience in care of the elderly and dementia care. We used the expert-by-experience to speak with people in their own language. That provided us with accurate information on what people knew and understood without terms being misinterpreted.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had returned the PIR.

We looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about. We also looked at other information we received which was sent to us from people who used the service or their relatives.

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.

During the inspection visit we spoke with 18 people who used the service, the provider [who is also the registered manager], five care staff, the cook and cleaner. We spoke with four relatives who were visiting their family member.

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked in detail at the care and support four people received, which included looking at their plans of care. We also looked at recruitment records, and records which were used in the quality assurance process.

Requires improvement

Is the service safe?

Our findings

We looked around the home, due to the refurbishment there was an additional amount of dust in the atmosphere. The provider told us this was a temporary situation and the changes to the dining room and lounges were due to be completed by the following week. We looked in a number of bedroom areas, in one there was a non-permeable floor covering. Even with this there was a strong odour of urine from the floor area. In another room there was a dark stain on the wall. We informed the manager about both areas at the time.

We also noted other areas that needed urgent attention. In the downstairs shower room close to the lounge, the raised toilet seat was rusting and the paint corroding. The plastic was stained. Paint was chipped on the water pipes and there was debris in the floor drain. The shower seat attached to the wall was dirty and heavily scaled. The shower chair was dirty and the plastic coating was coming away. There were also areas in the kitchen where there were cracked tiles and some of the wall tiles had holes in them. There was 'blu' tack on some tiles, and a build-up of dirt on an inset work surface at the edges.

On our return the following day, the stain was still on the wall. The provider said he was leaving the stain, to show staff what and how to clean areas thoroughly, as all staff were due to come to the home for a staff meeting that day.

There were further areas of concern in public bathrooms and toilets. There were rusty commode chairs and stained toilet risers. Both doors to the ground floor wet rooms had started to waste away, where the door facia had got wet and degraded. We drew the provider's attention to these areas. We also saw where there were cracked tiles to the kitchen floor and walls. We also reported these on to the commissioning team at the local authority and the Environmental Health Officer.

The provider stated all these areas would be improved immediately; some replacements would be done with the ongoing refurbishment.

We spoke with the cleaner who told us they change beds, do vacuuming, mopping, and clean the toilets every day. They also do a more thorough clean on a selection of different bedrooms each day. We saw these tasks were detailed in the cleaning schedule. They also undertake a number of laundry tasks, but the night staff completed the ironing.

We saw that gloves, aprons and hand sanitizer were available. Liquid soap and paper towels were also available. That meant that staff were able to protect people from the risk of cross infection.

We looked at the storage cupboard for cleaning materials which was appropriately locked. There were adequate supplies of cleaning materials, and the cleaner was conversant with COSHH processes and safety. We noted that mop heads and cloths were stored separately according to colour. That is important so there is less chance of cross contamination when this equipment is being stored.

The policy and procedure for cleaning was detailed and informed staff how to reduce the likelihood of cross infection or cross contamination within the home. When we asked the cleaner to explain what colour related to each area. The cleaner was unable to respond with the information that reflected the policy and procedure. That meant that staff were not following a consistent approach to infection control which could place people at risk.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of unsafe care or treatment.

Another relative stated that, "The [registered] manager is excellent but frequent staff change makes us worried." We spoke to the manager about this and he explained a number of staff had recently moved to other employers.

We understood from conversations with the care staff, that they understood their responsibilities to report on any concerns. Staff also understood the external agencies that were in place to assist with any concerns. We looked at the training records and confirmed that staff had undertaken safeguarding and whistleblowing training.

People could be assured that steps had been taken to maintain their safety. All the bedrooms had an appropriate door lock and had secure storage to keep their valuables safe. We saw that the corridor area was straight and wide which aided visibility and accessibility which supported people's safety when moving around the home.

Requires improvement

Is the service safe?

Due to the current refurbishment we observed that there was very limited room to move around in either of the lounges. When we spoke with people and their relatives, they were satisfied and understood the current situation was on a temporary basis. Talking with relatives, they said they had been well informed by the Manager in regards to the extension and have also been assured that it wouldn't have an effect the safety of their relative.

We saw a range of equipment used to maintain people's independence such as walking aids, hoists and wheelchairs which were stored safely and were accessible when required. Staff were able to explain how the equipment was used safely, and we saw that hoists were maintained on a regular basis.

We saw people being hoisted in public areas by staff, we also saw staff using the footrests on wheelchairs appropriately, which meant people were transferred safely.

We looked at peoples care plans which showed that staff had considered potential risks, and risk assessments had been developed to manage these risks. For example these covered risks of falls, use of bed rails, moving and handling and pressure sore risk assessments. We also saw that care plans and risk assessments were reviewed on a regular basis, some reviews being monthly.

Staff were able to describe how they supported people safely. That was consistent with individual plans of care, as well as staff being able to explain safety in general terms.

Regular fire safety checks were carried out, and each person had a personal evacuation plan. That was part of the care plan and detailed how to support the person in the event of an emergency. Senior staff used set procedures for reporting incidents, accidents and injuries. The provider notified us of incidents and significant events that had affected people's health and safety, which included the actions taken to reduce risks and prevent re-occurrences. The provider is aware of other relevant authorities that require to be informed if a health and safety issue came to light.

When we spoke with one person said, "This home needs more staff to cater [for] individual needs" and added they also noticed sometimes staff worked under pressure. We found there were enough staff to safely provide the basic care people required.

People's safety was supported by the provider's recruitment practices. Staff described the recruitment process and told us that relevant checks were carried out on their suitability to work with vulnerable adults. We looked at staff recruitment records and found relevant pre-employment checks had been carried out before staff worked unsupervised.

The staff on duty reflected the staff rota and the provider stated there was an on call rota to provide 'out of hours' support.

People told us that they received their medicines when they should. We spoke with people who used the service and their relatives with regard to their medicines. All were happy with their medicines they received, and added pain relief was provided by the staff whenever asked for.

Medicines were not always administered safely. We viewed the medication administration records, which are also known as [MAR] charts. The quantities of medicines received in the home are receipted for appropriately. That meant staff handled incoming medicines securely and could tell if there were any discrepancies.

The systems in place to check medication administration were not robust enough to pick up a number of issues that became apparent at our visit. We mentioned these to the manager who said there were checks in place that would alert staff to missed doses of medicines, but these were not documented. We also noted that the dates peoples' medicine commenced were inconsistent. That made the administration more time consuming and less safe.

We looked at the care plans of a person who required their food to be specially prepared. The person had seen a specialist health worker that had stated the type of diet required. However there was no detailed care plan or specific instruction to enable staff to administer medicines safely. We also noted there was no authority allowing staff to crush or conceal medicine in this person's food. That meant that staff acted without authority which placed which detracted from the person's human rights.

We looked at the medication policy and procedure, this was not up to date and did not inform staff on the full process of administering medicine, and had not detailed the new administration system that had been recently introduced.

Requires improvement

Is the service safe?

We looked at the procedure for applying people's creams and topical preparations which were kept in people's bedrooms. The tube of cream was not dated on being opened, and the application instructions to staff had been obliterated from the label. There was no mar charts for staff to sign for creams located in bedrooms, and no contributory body chart showing staff where and how to apply the creams. That meant there was potential for staff to over apply creams, or apply them to incorrect areas, and the person not benefit from them.

All medicines were stored in an appropriately locked room and staff recorded fridge temperatures which were within acceptable limits. However monitoring of the medication room temperatures was not being undertaken. This is necessary to ensure medicines are stored at an appropriate temperature, to guard against medicines deteriorating.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of unsafe care or treatment.

Requires improvement

Is the service effective?

Our findings

The people we spoke with also told us, staff understood their health care needs and they were supported by external health care professionals to ensure their needs were fully met.

We noted from staff files and training records that people had received induction training for their job role. Staff involved in the delivery of care and treatment received practical training in the safe use of equipment and their competency had been assessed by the provider and care manager.

We observed that staff were competent and confident when they supported people. When we spoke with staff one person explained they had only recently commenced in post and only undertaken part of their training. We looked at the training record and noted the person had been given training in moving and handling. They were working along with other staff so were supported until they could undertake a more comprehensive and effective training regime. Records showed that staff sought advice from health care professionals, which was then recorded in care plans and risk assessments.

Another member of staff explained the training courses they had undertaken, also explained about the different cleaning products needed, how they were stored and under what conditions they were to be used.

We noted that the lunch time meal was served in the two lounges. That made it difficult for people to have personal support where they needed assistance with their meals, and difficult to maintain communication with people throughout the meal. That was due to the restriction on space, and staff being unable to place themselves at an appropriate position and height to fully maintain eye contact. This showed us there was inconsistency when providing effective care and support.

We observed one person being assisted to eat a meal that had been specially prepared by the cook. The person was assisted by two different members of staff, the first helping them appropriately. We then observed the second member of staff. They told us the person had a reduced bodyweight and the nutritionist had requested additional food to build the person back up. However the consistency of this beaker appeared to be thinner. While they were being assisted to eat, the person's body language changed. They became distressed which was obvious in relation to how they moved their arms and legs much more quickly and their breathing became faster. They also appeared to the inspector to be trying to push the beaker away. That meant that staff did not respond quickly to peoples changing circumstances and needs which placed them at risk of choking.

Following the incident we looked at the person's care plan and spoke with the cook. The care plan specified that they should be offered 'Texture C pureed diet and stage one thickened fluids'. There was no further information for staff on how to achieve Texture C nor was there a detailed care plan on nutrition for this person. That meant there was a risk of this person choking due to the staff not being thoroughly trained, or have suitable information to produce care at a consistent and safe level.

We spoke with the cook who said that they just puree the food, and added they had not been trained in anything else. The cook added, it was up to the staff to get the food to the right consistency.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of unsafe care or treatment.

We looked at this person's care plan, and the letter from the speech and language therapist, who are also known as SALT staff. The letter of 3 March 2015 stated the person should have a specific diet and gave instruction on the consistency of their diet and degree fluids were to be thickened to.

At times other than lunch, staff responded to people's needs and requests for assistance. However our observations at lunch time confirmed that there was not sufficient staff available at that time to meet people's needs. We spoke to the provider about the staff numbers and he confirmed that the staffing would be adjusted to meet people's needs. He added that he felt the situation was temporary, and due to the dining room being out of action due to the refurbishment.

People told us they had sufficient amount to eat and drink. There was a choice of culturally appropriate Asian meals, refreshments and snacks offered. A relative told us, "We

Requires improvement

Is the service effective?

were told we couldn't help to feed [named resident] anymore because she needed a trained worker to help her swallow." I suppose that's good really, because that's what they [the care staff] are trained to do and we're not."

The cook had sufficient information about people's dietary needs, food tolerances and preferences. The menu showed that a variety of meals were offered, which were a nutritionally balanced and were based on purely vegetarian choices and meals to suit people's cultural and religious needs. The registered manager ensured the food stocks were plentiful and the cook monitored the food was stored at the correct temperatures. The cook also told us also "Even though we store food in the freezer staff go and buy fresh vegetables on the day from the local shops."

We saw the cook had a menu to follow, though told us they deviated from the set menu. She told us, "This is not my home this is [the] residents home and they can choose whatever they prefer to eat." That meant on some days people chose alternatives to the meals that were on offer. On occasion that meant there were three different main meals produced, as well as home-made rice, (naan) bread and parathas. The cook also said that the majority of people were vegetarian and that for the two people who ate meat, the manager arranged for meals to be brought in. That meant there was a nutritionally based menu offered to people which reflected their cultural preferences.

We also saw that mid-morning snacks were available for people, they were offered either a small bowl of cut up fruit or a yogurt. Drinks were also available. One of the residents told us they had snacks and drinks throughout the day and were offered a seasonal variety of fruits. The person added, "I like my fruits to be cut in small portions and they do remember my preferences." Another said to us, "Sometimes we have Indian snacks such as samosa, ganthia, parantha's."

We saw from most people's care records that an assessment of their nutritional needs and plan of care was completed which took account of their dietary needs. People's weight was recorded if there was a specified need and staff knew how to help those who needed extra support.

People told us they able to maintain their health and had access to health care support as and when required. People's care records also confirmed that they received health care support from a range of health care professionals, which included doctors, specialist nurses, optician and outpatient appointments at the hospital. An advance plan of care (DNAR) was in place where people had made an advance decision about their care with regards to emergency treatment and resuscitation. People could be confident that staff would act in accordance with their wishes.

Records showed that additional checks were put in place for people who required additional monitoring due to their health needs. Staff acted quickly to report any concerns about people's health.

The provider and staff had a good understanding of MCA and DoLS and their role to protect the rights of people using the service. The staff our expert spoke with said that they had not had much training since commencing work at the home.

Staff knew the procedure to follow where they suspected a person's liberty could be deprived. Staff told us that people had various levels of capacity and understanding, which varied throughout the day and gave examples of how they supported people to make decisions about their daily life. One member of staff pointed out that a person may have the capacity to decide what meal they would prefer, but not to be able to go out of the home alone.

We observed that staff sought consent before assisting and supporting people with their needs. At the time of our visit a number of people were being assessed for a deprivation of liberty assessment [DoLS].

Records showed that some people had given written consent to their care and treatment. We saw mental capacity assessments had been completed because some people did not have the mental capacity to consent to care and treatment. That showed that the principles of the MCA Code of Practice were followed in relation to best interest decisions.

Good

Is the service caring?

Our findings

We spoke with a number of people who lived at the home they told us that they felt staff cared for them safely. One person told us, "I am more happy [here] than my own home, staff are lovely, I am only here because of the staff." Another relative said, "I can't think of any other place for my mother, my mum's happiness comes first and this is her home."

We spoke with four relatives who felt their family members' were well cared for.

Throughout our observations we found staff were kind, compassionate and caring. We saw there were positive relationships had developed between people that used the service and the staff team. Staff spoke to people in a friendly and respectful manner that was culturally appropriate. All the staff were able to converse in a range of Asian languages as none of the people living in the homes first language was English.

When we spoke with people living there told us, "The staff here are all very good, you're looked after well," and added, "I think they're very kind." Another person said, "Some [care workers] are better than others, but on the whole they are good with you." Another person told us, I am just passing time here, staff are busy with other tasks so they can't give much time to spend with you.

People told us that care workers were polite, respectful and protected their privacy. One person said "They [the care workers] always knock on my door and ask if they can come in. That's respect, I think." We observed polite and respectful interactions. One relative said "The staff are all very friendly, but they're also very courteous to everyone." Another relative said "I always have a laugh with the staff when I come [to visit]. And added "I know [named relative] likes them [the staff], even though she can't tell you. Another relative said, "The staff here makes the effort to know you by name, and this makes us comfortable and it makes us feel as though we are at home."

We observed care interactions that were kind, patient and sensitive. We observed one care worker speaking kindly and sensitively with a person they were supporting to eat their meal in their bed room. We observed another carer that assisted a person to eat their special diet which was a pureed meal, in a beaker. The person appeared to be relaxed and the staff member wiped food from their chin regularly. That meant that people were treated with dignity.

People told us that they were not aware of the detail in their plans of care. One person that used the service said their family was involved with all the paper work and they were not interested as long as they had been cared for properly.

We observed staff offered people everyday choices and respected their decisions. Staff spoke clearly to people, and explained what they were doing and where appropriate in the persons first language.

People looked clean, well-cared for and were wearing clothing, jewellery and make up of their choosing. People were supported to observe their religious and cultural practices and staff were aware of this.

People's care records confirmed that people or their family member had been involved in decisions made about their care and support. Care plans took account of how the person wished to be supported, which included respecting individual preferences, religious and cultural needs. We noted that care plans were reviewed regularly and were updated when changes were required.

People gave examples of how staff respected their privacy and dignity. People whose first language was not English were able to converse with staff who also spoke the same language. That showed staff respected people's wishes, had awareness and were respectful of people's individual needs.

We observed that staff knocked on doors and asked if they could enter. People in the home and their relatives said that the staff respected their privacy and dignity and relatives can choose to close the bedroom or lounge door at any time whilst visiting.

Good

Is the service responsive?

Our findings

We spoke with a number of people who lived and worked at the home. People told us they were satisfied with the care and support they were offered to enable them to maintain their daily lifestyles. No-one living in the home told us they had been involved in the assessment of their needs or in the development of their care plan.

One relative told us, "[named person] is very happy here and I am quite confident with staff at the home, as they know more than me because they are with [named person] 24/7 and I am happy to see that they are comfortable and have been looked after well."

When we spoke with people they told us that, it would be nice to have more staff so they could offer individual support especially with dementia and provide someone to talk to. We recognised that due to the on-going refurbishment staff were unable to fully offer their normal routine, for example meals were all served in lounges.

We saw the staff were still responsible for answering the door and telephone through the lunch time meal period. That meant there were not dedicated staff at lunchtime, which detracted from the time staff had to spend with people. We spoke with the manager about this who agreed to look at changing the staff allocation at meal times.

People living at the home and their relatives, they told us staff were caring and compassionate in their approach. People were given choices about how they wanted to spend their day so they were able to retain some choice in their everyday life. They also told us family and friends were able to visit when they wished and staff encouraged relatives to maintain a role in providing care to their family member.

The relatives we spoke with told us that they had a 'residents and relatives' meeting last year. They [the staff] discussed a trip for people living in the home, and they invited relatives to accompany them. One of the relatives we spoke with said, they asked the manager to invite the priest from the temple to do the prayer with those on the outing. They also said she noticed priest used to visit the home regularly, but suddenly stopped visiting. We spoke with staff to enquire why the priest had stopped visiting, but they were not aware of the reason. The staff stated they would contact the priest to see if they could re-commence their visits.

Relatives also told us that they could visit when they liked. The staff told us they might ask people to ring if they were intending visiting late at night, but generally there were no restrictions to visiting times.

Relatives told us that they felt their family members' were safe. One relative told us that they had made suggestions about the care their family member received. The manager resolved the situation with a positive outcome for everyone involved.

We looked at people's care records and found that people's needs were assessed prior to them moving into the home. The assessment process was undertaken by the provider or care manager, and also sought the views of the person's relatives or a representative. We found care plans to be individual, were personalised and took account of how people liked to be supported. Plans also included the person's life history, hobbies, interests and what was important for them, for example being dressed in culturally appropriate clothes such as a sari or a Punjabi suit.

Care records showed that people's care plans were reviewed periodically. Relatives were invited to attend review meetings which also included health care professionals when required. That meant people could be assured that staff were provided with up to date information to include in the updated care plan.

We spoke with an activity worker who told us that activities were often personalised such as painting, puzzles, art & craft, nail painting, exercise and short day trips rather than group activities. We saw people undertaking some activities, at the time of our visit. We also observed a member of staff, who was performing hand massages for people. We spoke to a beautician who told us they attend the home once a month if anyone requests reflexology. That meant the staff consider people's wellbeing within their normal day to day activities.

None of the people we spoke with had made a complaint about their care but they told us if they had a problem they would speak to a senior care worker or the registered manager.

Relatives told us they knew how to raise concerns and knew where they could obtain a copy of the complaints procedure, which were freely available in the foyer of the home. The provider had systems in place to record complaints. When we viewed the records they showed the service had received two written complaints in the last 12

Good

Is the service responsive?

months and no verbal concerns. Both the written complaints were investigated appropriately, and the staff were involved in the outcome. The subject was recorded in the minutes of a staff meeting.

The provider told us that he was attempting to get the staff to realise what appeared to be insignificant comments made by people, were also to be seen as complaints and required to be recorded. The provider also said he was in the home most days and had an 'open door' policy. That meant people who used the service, their relatives or friends and health care professionals could speak with them openly about any issues.

Prior to our inspection we contacted social care professionals for their views about the service. Staff from the Local Authority told us that there most recent quality assurance framework [QAF] monitoring visit, returned an 'above average' score. That meant the home had an above average score for a set number of quality indicators.

Requires improvement

Is the service well-led?

Our findings

People who used the service and their visiting relatives spoke positively about the open culture and communication with the staff. People who lived at the home and their relatives we spoke with knew the provider and care manager and felt they could approach them with any problems they had.

We noted that the provider interacted politely with people who lived at the home and people responded well to him. When we spoke to the provider, it was clear he knew people and their relatives intimately and was able to speak in some detail about them.

We observed staff worked well together that created a calm and organised atmosphere. Staff communicated well with people using the service, spoke clearly and gave the person time to reply. This demonstrated a person centred approach to care.

The provider had a clear management structure within the home, which meant that staff were aware who was on duty or on call out of hours. The provider was supported by a care manager, who undertook the day to day management duties, whilst the provider was not in the home.

The provider understood their responsibilities and displayed a commitment to providing quality care. They told us it was important that people's care needs were met timely and respectful manner by staff that were culturally appropriate, trained and caring. The provider kept their knowledge about health and social care up to date and knew how to access support from external health and social care professionals.

The provider visited the home most days to monitor the day to day care, as well as any improvements. That also provided people with an opportunity to make comments or raise concerns directly to him.

Care staff understood their roles and responsibilities and knew how to access support. Staff had access to people's care plans and received updates about people's care needs at the daily staff handover meetings. There was a system of planned meetings to support staff, and included both one to one and group meetings. Staff had the opportunity to discuss their roles, training needs and to make suggestions as to how the service could be improved.

There were systems in place for the maintenance of the building and equipment. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained. Staff were aware of the reporting procedure for faults and repairs. The provider had access to external contractors for maintenance and to manage any emergency repairs.

Meetings were held for the people who used the service and their family or friends where they had the opportunity to share their views about the service; raise any issues that they may have and make suggestions as to how the service could be improved. That meant people were informed of changes within the service, encouraged to be involved and could influence how the service could be improved so that they and others received a quality service.

We looked at the record of quality assurance undertaken by the provider and care manager. Though these were completed regularly they only required a tick signify a check had been completed. There was no detail instruction to specify how the checks should be undertaken and what should be looked at. That meant we could not be sure how thoroughly areas were cleaned or disinfected appropriately.

We asked the provider to look at the cleaning schedules. These should describe in detail what and how areas should be cleaned, the regularity of cleaning and how cleaning and in some cases disinfection should be undertaken. We looked at the procedures but these were not detailed enough to allow the staff to undertake these tasks efficiently.

We received positive comments from social care professionals. They told us that the service was well managed and the provider was professional and promoted care that was person centred.

They found the provider was professional, approachable, organised and promoted person centred care. They felt that the service worked hard and provided a culturally appropriate service.

The commissioners who funded people's care packages shared their contract monitoring report with us. The report showed that the Diwali Nivas was meeting the quality standards set out in the contractual agreement.

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 **People were not protected from the risk of unsafe care or treatment.**

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