Bestcare Ltd

Vishram Ghar

Inspection report

120 Armadale Drive
Netherhall
Leicester
Leicestershire
LE5 1HF

Tel: 01162419584

Date of inspection visit:
06 December 2016
07 December 2016

Date of publication:
18 January 2017

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**

Summary of findings

Overall summary

Vishram Ghar provides personal care and accommodation for up to 40 people. On the day of the inspection the acting manager informed us that 35 people were living at the home.

This inspection took place on 6 and 7 December 2016. The inspection was unannounced and was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert for this inspection had experience of the care of older people and older people living with dementia.

At our last inspection in September 2015 the service was not meeting the regulation we inspected with regard to keeping people safe. We followed up these issues and found some improvements had been made, though further improvements were needed to ensure people were supplied with a comprehensive service.

A registered manager was not in place. The previous registered manager had left their employment three months before the inspection. The acting manager stated that the recruitment process was in place and supplied us with information indicating this was the case. 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 and associated Regulations about how the service is run.

People using the service and their representatives we spoke with said they thought the home was safe. Staff had been trained in safeguarding (protecting people from abuse) and generally understood their responsibilities in this area.

People's risk assessments have not always been comprehensively followed to ensure people how to save care.

Staffing levels were not fully sufficient to ensure people were safe at all times.

People using the service told us they thought medicines were given safely and on time. We found in the main, medicines had been supplied to people as prescribed.

Systems to ensure that the premises were safe for people to live in were not fully in place.

Staff had not been subject to comprehensive checks to ensure they were appropriate to work with the people who used the service.

Most staff had been trained to ensure they had the skills and knowledge to meet people's needs, though more training was needed on relevant issues in order there was assurance they could meet all the needs of people.

Staff generally understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have an effective choice about how they lived their lives, and the service had obtained legal approval for limiting people's choices when necessary for their best interests.

People had plenty to eat and drink, most people told us they liked the food served, though some people wanted more choice and variety. People had been assisted to eat when they needed help.

People's health care needs had been, in the main, protected by referral to health care professionals when necessary.

People and their relatives told us that staff were friendly and caring and we saw many examples of staff working with people in a kind and compassionate way.

Evidence was not in place that people and their relatives were involved in making decisions about their care, treatment and support, though evidence was lacking in some care plans.

Care plans were individual to the people using the service and covered their health and social care needs.

There were not sufficient numbers of staff to ensure that people's needs were responded to in good time.

Activities were organised to provide stimulation for people, though activities tailored to people's needs had not been frequently provided.

People and relatives told us they would tell staff if they had any concerns and were confident they would be followed up to meet people's needs.

Management had not comprehensively carried out audits and checks to ensure the home was running properly to meet people's needs.

We found breaches of regulations in respect of ensuring the safety of people using the service, and not having quality assurance systems in place to ensure the effective running of the service. We will closely monitor the service and take more robust regulatory action if the service does not improve.

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 had not always received safe care as set out in their risk assessments to protect their safety. Staff recruitment checks were not comprehensively in place to protect people from unsuitable staff. There were not enough staff to safely meet people's needs. People and relatives told us that people were safe living in the service. Staff knew how to report any suspected abuse. Medicine had, in the main, been supplied to people as prescribed.

Is the service effective?

Requires Improvement

The service was not fully effective.

Some staff had been trained and supported to meet people's needs, though more training was needed for some staff to enable them to effectively meet people's needs. People's consent to care and treatment was sought in line with legislation and guidance. People told us that they, in the main, liked the food served though there were some issues people wanted to see improved. There was collaboration with and referral to health services to maintain people's health but this had not always indicated that routine appointments had been arranged by staff.

Is the service caring?

Good

The service was caring.

People and their representatives told us that staff were friendly, kind and caring. We observed this to be the case in all interactions we saw. Staff protected people's rights to dignity, independence and privacy. People or their representatives had not always been involved in planning their care.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans contained information for staff on how to respond to people's needs. Staffing levels were in not fully in place to ensure

to respond to people's needs. Some activities were available to people, though this availability was limited. A system to comprehensively act on complaints was not in place.

Is the service well-led?

Requires Improvement

This service was not consistently well led.

There was no registered manager in post at the service. Systems had not been comprehensively audited and followed up with needed action in order to ensure a quality service was provided. Staff told us the management team usually provided good support to them but the acting manager was not fully able to carry out a management role due to not speaking the first language of people living in the service. Staff had a clear vision of how friendly individual care was to be provided to meet people's needs.

Vishram Ghar

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 you speak my language duly and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert for this inspection had experience of the care of older people with dementia and could speak the first languages of the people who lived in the service.

Before the inspection we reviewed the 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.

We also reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We used a variety of methods to inspect the service. We observed how people were supported during their lunch and during individual tasks and activities. We also spoke with nine people living in the service, the acting manager, a director of the company, a training consultant, four relatives, four care workers and the cook.

We looked at records relating to all aspects of the service including care, staffing and quality assurance. We also looked in detail at four people's care records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in September 2015 we found t that people were not supplied with safe care. We followed up these issues and found there was still some improvement required.

We saw that people's care and support had not been consistently planned and delivered in a way that ensured their safety and welfare.

For example, the risk assessment stated a person needed to have hourly monitoring of their needs. A fluid chart was in place to monitor whether they were being supplied with fluids to make sure they were protected from dehydration. However, the assessment did not specify how often the person needed to be supplied with fluids. According to a record on 3 December 2016 they were without fluids for five hours. On 4 December 2016 they were without fluids for four hours. This meant the person was at risk of dehydration.

The same person was assessed as needing to have assistance to maintain their continence. The risk assessment specified that staff needed to check the person every two hours and, if needed, to change the continence equipment. However on 4 December 2016 the records indicated that the person had not been checked for six hours. On 5 December 2016 we found the person had not been checked for six hours. Following this check there was a gap of five hours between the next check. This demonstrated that people's safety was being placed at risk.

A care plan for another person who needed assistance with their continence did not specify how often they needed assistance. There was in place only a general statement about the importance of checking the person throughout the day and night. We again found the person had up to 6 hours between the times they had been checked. This meant there was a risk to the integrity of people's skin, which meant they were at risk of developing pressure sores.

This person had been assessed as being at risk of developing pressure sores. The risk assessment included relevant information such as the provision of a specialist mattress. We checked the pressure of this mattress. This indicated a pressure of "Normal." When we checked the risk assessment, it stated, "Mattress set to 50 flow." This did not equate to the setting on the mattress, which meant a potential risk to this person's safety in developing pressure sores.

The acting manager said these issues would be followed up with staff.

We looked at another care plan of a person with diabetes. This indicated that should their blood sugar level fall below four, then staff needed to supply them with assessed food or drink to help raise this level. We looked at the "Home Monitoring Diary", which recorded these checks. We found that on 26 November 2016, the level was recorded at 3.7, which was below the safe assessed level. We saw no evidence in this diary or in the daily records that staff had taken action to supply the person with the assessed help. The acting manager said this issue would be followed up. This meant there was a risk to this person's health on this occasion.

We looked out the fire risk assessment. This stated, "Fire drills to take place on a regular basis and incorporate both day and night time staff." We found regular fire drills had not had taken place. A fire drill had taken place in September 2015. However the next fire practice had not taken place until an unplanned fire practice in November 2016, over a year later. There was no evidence to indicate that all staff had received practice in a fire drill situation in the past 12 months. We saw the fire risk assessment. This stated the assessment needed to be reviewed in June 2016. We saw no evidence this had taken place. We saw that fire signs had been taken down due to redecoration of ground floor corridors. The acting manager said he would arrange for signs to be replaced within 48 hours. He later confirmed this work had taken place. We concluded that people's fire safety had not been comprehensively protected.

During our inspection visit we did not find there were enough staff on duty to meet people's needs and talk with people. Two people we spoke with told us that they needed more staff so they were not left for a long time in the toilet waiting for assistance. One person said, "I can manage myself now, but I am getting older and am worried what will happen when I need full assistance…staff always seem very busy."

One relative told us, "There is not enough staff here. They are not always in the lounge. They could fall and there is no one to help them." Another relative said, "Sometimes I am worried…in regards to their personal care, they take a long to take them to the toilet, and that's not nice, as they feel uncomfortable." Another relative told us, "I think they are very kind but busy so they are always in a rush." Another relative told us, "Staff huff & puff showing that they are very busy, they don't have much time to talk to individuals ."

We found, in a main lounge, there was a system that staff checked the lounge every 15 minutes to see if people were ok. However, this meant if someone had fallen, or a person became agitated and was at risk of assaulting another person, staff would not be in at hand to offer support and assistance. This meant, without staff presence, there was a risk to people's safety. We also found that not all checks had been carried out on a 15 minute basis. We saw a record on 6 December 2016 which showed there had been a 28 minute gap between 9.32 am and 10 am, which was a further risk to people's safety.

The Provider Information Return stated that all but two of the people living in the home lived with dementia. Of these, 29 people had a physical disability and two people had other mental health needs. Most people needed the assistance of two staff to meet their care needs. This meant when staff were providing assistance to two people are needed two staff each, only one other staff member available to provide assistance and supervise care needs for the remaining people living in the service. When the staffing levels reduced in the afternoon and evening periods, this level of assistance and supervision was reduced by one staff member. This meant people were not provided with safe care and supervision. Without continuing staff presence in lounges, people were at risk from falling and from anyone whose behaviour challenged the service.

In the main ground floor lounge, there were three call bell leads. We saw that two of these were tied up. This meant they were not accessible to people if they needed to call for assistance. The acting manager told us this would be dealt with. We checked later and found the call bell leads had been untied. We saw a comment in the residents' survey of June 2016 which stated, "Emergency buzzer for each resident would be helpful." This indicated to us this was an issue which had not been properly progressed to ensure that people have the means to call staff when they needed assistance. This did not protect their safety. The acting manager acknowledged this and said the provider was considering supplying personal individual call bells to people which would give them the means to obtain help quickly.

One relative told us that her family member wondered into other people's rooms. This was a concern as they had drunk the milk of the person living in the room. They had been provided with a sensor mat, but this

had had not alerted staff to provide assistance. The relative was worried that other people might pose a danger to their family member if they went into their rooms.

Staff recruitment practices were not fully in place. Staff records showed that before new members of staff were allowed to start, checks had been made with previous employers and with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and ensure that staff employed are of good character.

However, for two staff records we looked at, a poor reference had been received from their last employer. There was no evidence that a risk assessment had been carried out to determine whether they were fit to provide care to people. There was also no evidence in place as to whether they needed to be monitored and supervised to ensure people received safe care. Neither of these staff had received supervision of recorded observation of their work to monitor their performance and ensure people safely protected from poor care. The nominated individual stated he had advised the previous registered manager not to employ these people as care staff but the registered manager went ahead and did this. He told us that the inspection that he had warned a director of the company about this. However, after the inspection, he said he had checked this and thought he had not warned the director. This situation meant that systems were not comprehensively in place to properly demonstrate staff were safe to supply personal care to people.

In general, we found that the premises had been kept clean. This was an improvement from our last inspection visit where we had found unclean toilets and bathrooms. However, there were some stained sheets on people's beds. Staff generally wore protective clothing to prevent the risk of infection. However, we saw an instance where a staff member gave pieces of apples to people without the wearing of protective gloves. These issues were unsafe as they were possible infection risks.

This was in breach of regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. You can see what we have told the provider to do at the end of this report.

People we spoke with told us they felt safe living there. One person said, "You know you can't go out of the building without any assistance due to my poor mobility and that's fine, it feels safe like that."

Staff had been aware of how to keep people safe. For example, to make sure that people were not rushed when personal care was supplied. We saw people using walking aids such as frames, and staff providing support to people walking to make sure they were safe. Staff appeared to understand the help that was needed to maintain safety and wellbeing and this was provided when needed.

During the visit we saw no environmental hazards to put people's safety at risk from, for example, tripping and falling. Health and safety audit checks showed that water temperatures had been checked, there was servicing of equipment such as hoists and fire records showed that there was a regular testing of equipment and fire alarms. However, one hoist on the ground floor was broken. The acting manager said he was aware of this and the hoist was being arranged to be repaired. At the time of the inspection visit, this was not an issue because only one hoist was needed with people accommodated on the first floor, whilst the lift was being repaired.

A procedure was in place which indicated that when a safeguarding incident occurred, management staff were directed to take appropriate action. Referrals would be made to the local authority and other relevant agencies with CQC being notified, as legally required. This meant that other professionals outside the home were alerted if there were concerns about people's well-being, and the management did not deal with them on their own.

Staff told us me they were happy working at the service and had never witnessed any abuse towards people living in the service. We spoke with staff about protecting people from abuse. Staff knew how to recognise the signs of possible abuse and their responsibility to report it. One staff member said, "We know we have to report this and if nothing is done, I would go further." The provider's safeguarding policy (protecting people from abuse) properly set out the role of the local authority in safeguarding investigations.

People told us they had received their medicines at the time they were supposed to get it. However, one relative told us that medicines had not been available when their relatives had been discharged from hospital. We checked medicine records for the person. We found medicines had been available but had not always been signed by staff to indicate they had been supplied to the person. This meant there was a risk that the person's health had not been safely protected if they had not received their medicine. Another relative told us as far as they were aware, there had been no problems with people receiving medicines from staff.

A system was in place to ensure medicines were safely managed in the home. Medicines were kept securely and only administered by staff that had been trained and assessed as being able to do this safely.

We looked at medication administration records for people using the service. These showed that medicines had been given and staff had largely signed to confirm this. There was useful information in place for staff to refer to such as whether the person had an allergy and the person's medical history.

We observed some people being given their medicines by staff. This was carried out properly. People were encouraged to take their medicines and were given fluids in order to be able to take their medicines more comfortably.

Temperature checks for the fridge holding medication had been carried out and these were in line with required temperatures to make sure the effectiveness of medication was safely protected.

We saw protocols in place for PRN (as needed) medicines. Protocols ensure that medicine is supplied consistently to people to ensure their health needs are safely met. Protocols were set out by the prescriber, usually the GP, to ensure medicines supplied were safe to protect people's health.

Requires Improvement

Is the service effective?

Our findings

People and relatives we spoke with thought staff were able to meet people's needs. One person said, "They seem to know what they are doing. I think they do get training."

The activities organiser told us, "We have one trainer who works twice a week and looks into all the training such as, health & safety, safeguarding, food and hygiene and many more."

Staff said that the training they had received had been effective in giving them the right skills and knowledge to enable them to support people appropriately. A member of staff said, "I have had a lot of training. It helps me with my job. They are planning more I think." Staff also told us there were opportunities to discuss any issues with senior staff to help them provide effective support to meet people's needs.

The staff training matrix showed that staff had training in essential issues such as dementia, protecting people from abuse and moving and handling techniques. There was also evidence that a number of staff had qualifications and others were encouraged to undertake vocational training so that they could provide effective care to people. We spoke with the training consultant of the company to explain to us that staff were going to undergo commence Care Certificate training, which is nationally recognised comprehensive training on a number of essential care issues. This was confirmed by staff we spoke with.

We saw that induction training such as ensuring people's dignity, infection control and how to protect people's health and safety had also been provided to ensure that staff understood how to effectively meet people's needs.

We saw that some staff had not undertaken training in relevant issues such as dementia and end of life training. The acting manager said further training would be provided. We received information from the acting manager after the inspection which set out that staff would receive additional training. This would mean that staff would be fully supported to be aware of and able to respond effectively to all of people's assessed needs.

Staff told us that they had received supervision in the past. Supervision included relevant issues such as staff training and health and safety issues, to support staff in their roles providing personal care. However, when we looked at staff records, we found supervision had not been supplied to staff for some time. For example, staff had not received supervision for over nine months. The acting manager said this issue would be followed up to ensure staff received regular supervision.

We saw that some staff had received training to be aware of their responsibilities in relation to the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. Other staff had been booked to attend this training. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. The DoLS are a law that requires assessment and approval to ensure that any restrictions are in people's best interests, to keep them safe. The staff we spoke with were unsure of their responsibilities in relation to the MCA, though

they were aware they needed to report any issues to the management of the service, and were aware of seeking people's permission before providing personal care. The acting manager said this issue would be discussed with staff.

At this inspection we found evidence of mental capacity assessments for individuals and best interest assessments. Where people were unable to make decisions themselves, the procedure had been followed to protect their rights under the Act. There was information in place for assessing people's mental capacity. Deprivation of liberty (DoLS), applications had been made with proper authorisations granted to enable staff to take decisions in people's best welfare interests.

People told us that staff always sought their consent when supplying personal care to them. We observed during the inspection staff explaining to people what care they were going to provide and seeking their consent before supplying this, such as helping them to move from one place to another.

One person we spoke with told us, "My son particularly chose this home because they offer Guajarati food…I am satisfied." Another person said, "Food is ok".

People we spoke with said they thought the food and drinks they were supplied with was generally good. However, one person said that due to their stomach ulcer they were not supposed to have chilli in their food. However, they had been supplied with food with chilli in it and they were advised by staff to add yoghurt to reduce the heat in the dish. They were not satisfied with this advice. Also, two people told us that teatime meals were not very good.

Four people told us they were not fully satisfied with the food. One person said "They use less green vegetables especially in the evening and sometimes they provide pizza/chips, puas (rice flakes) or onion bhaji which is not filling and we feel hungry afterwards." They also said, "Sometimes we ask for chapattis and they refused." We spoke with kitchen staff and they told us they ordered fresh vegetables from local shops and food was freshly cooked. The acting manager said that these issues would be followed up following a review of food menus.

Other people spoke with told me the meals were good and there was always plenty to eat and drink. There was a choice of meals at lunchtime. The food served was home cooked and looked appetising. People seemed to enjoy their meals and were allowed time to eat at their own pace. There was a choice of drinks being offered and disposable protecting aprons were provided to those who required them. Staff informed people with diabetes that there was an alternative dessert for them to have. One person refused to have the available pudding so the staff member offered to him a suitable alternative.

Staff encourage people to drink fluids. A person refused to eat, so staff prompted the person to eat and offered them a sweet yogurt drink. Another care staff was supporting a person to eat by themselves and assisted her by providing adapted cutlery.

Three people said they recently attended a residents meeting and discussed with the acting manager that they need more variety on their menu and to include more fresh green vegetables. The acting manager told us he had recently completed a food survey and will follow up its findings to ensure people's needs were met.

People had eating and drinking care plans which included a list of their likes and dislikes, weight charts, and risk assessments concerning their nutrition and hydration. Food and fluid charts were in place for people who needed their intake monitored. When specialist advice was needed we saw evidence that staff referred

people to relevant professionals.

People with swallowing difficulties were supplied with soft and pureed food to help them swallow. The food served appeared of good portion size and was nutritious. We saw that people were offered drinks frequently by staff. People also told us that drinks were available at any time and we saw that staff encouraged people to drink. This prevented people suffering from dehydration.

The cook told us that when a newly admitted person came into the home to live, she was supplied with information by management about their nutritional needs. When we asked to see evidence of this, the cook said she remembered it. There was no room information to assist other members of staff in providing suitable food and fluids for all the people living in the service. The acting manager said this would be followed up to ensure people were always provided with suitable food that met their needs.

People told us they were satisfied that staff had ensured they had prompt access to health professionals when needed. People told us they had all the medical services they needed, such as GP's, hospital services, nurses and a chiropodist.

We looked at care records which showed that medical agencies , such as the district nurse and GP, had been appropriately referred to. However, a care plan we looked at showed that the last chiropody appointment someone had was over nine months previously and the person had not had a dental appointment since 2011. The acting manager said these issues would be followed up.

We saw records of accidents. We found staff had referred people to medical services when they had a potentially serious accident. Staff told us that they were able to alert management staff to medical concerns and these issues were followed up.

Good

Is the service caring?

Our findings

People told us that staff were very caring. One person said, "The staff are very supportive." Another person told us, "I appreciate their kindness and I'm grateful that they are always polite." A relative said, "Care workers are friendly." Another relative told us, "I think the standard of care here is good."

A relative of a person who had recently lived in the service said that staff had always been always friendly and caring to their family member. We also saw positive comments from people and relatives in information contained in surveys. One person stated, "Staff are always very nice."

We saw that the way staff related to people living in the service was relaxed and cheerful. Staff team appeared to be involved in ensuring the comfort and wellbeing of people, and were polite and respectful to people.

We observed one staff member speaking kindly and sensitively with a person they were supporting to eat their meal in the lounge. The person was unable to speak, but their facial expression showed recognition and affection when the staff member spoke.

We observed when staff were using hoists to transfer people onto wheelchairs, they handled the person gently and also talked to them. Staff covered them with a blanket to ensure their dignity. We saw a staff member assisted a person to eat at their pace and with patience.

People could choose whether to have their bedroom doors open or closed whilst they were in their bedrooms. One person told us, "I prefer to stay in my room and watch TV and have lunch in my room too." They told us that their wishes were respected by staff.

We observed people who wanted to mobilise independently, but slowly, being allowed doing so. A staff member was encouraging people to eat themselves which promoted their independence.

One person told us, "They (staff members) always knock my door and ask if they can come in. That's respect, I think."

All the people we spoke with considered staff to provided personal care when needed and enabled them to make personal choices. A staff member told us that she gave people the choice of wearing clothes that they liked, and she was aware of the colours that people also preferred when choosing clothes. Another staff member said that people all had individual choices. For example, some people liked to spend more time having a shower.

The philosophy of care at Visham Ghar was set out in the literature of the service. This emphasised respect for people, encouraging independence, respecting privacy and for people's rights and needs to be respected. The training consultant said that he had been observing care practice and emphasising that staff needed to take a time when relating to people. This helped staff to provide a caring service.

People told us that their religious and cultural needs were met by the service. They said that staff were able to speak with them in their first language. Appropriate diets were provided to ensure cultural needs were met. There were separate dining rooms for people who were vegetarians and non- vegetarians. This was important in order to respect the cultural and religious needs of the people living in the service. In one main lounge we found religious artefacts displayed, appropriate to the religious needs of people living in the service. In people's care plans, there was information about their religious needs. This showed us there was respect for people's cultural and religious needs.

Staff told us that they respected people's privacy and dignity. They gave us examples of this such as protecting people's dignity during personal care by covering any exposed areas.

Staff said they promoted people's independence by seeing what people could do for themselves, such as being able to wash their hands and faces and encouraging them to do this. A staff member told us, "We all provide respect and dignity. This is very important." We saw the person had some food on their chin. A staff member noticed this and gave them a tissue so that they could wipe this away themselves.

Throughout our inspection we noted the staff we spoke with demonstrated an awareness of the likes, dislikes and care needs of the people who used the service. We observed that people who used the service had the opportunity to make choices about issues. For example, people were asked what food they wanted to eat. Staff asked people where they wanted to sit in the lounge.

These issues showed that staff were caring and respectful in their dealings with people and respected their rights to choose their lifestyles.

Most people we spoke with told us that staff knew what care they needed and did not feel they needed to be involved in their care plan. One person told us they were involved in setting up their care plan and said, "We talked things through and we seemed to come up with a plan and this was discussed in my language."

Some people told us they could not remember being involved in setting up of their plan when they first were admitted into the home. There was no evidence we saw in plans that this had taken place. The acting manager said this would be followed up to ensure that people or their representatives always had involvement in setting up their care plans to make sure their needs were recorded and acted on. We were later sent information that indicated that people had been informed that they could see their care plans.

Requires Improvement

Is the service responsive?

Our findings

We observed when staff were using a hoist to transfer people onto wheelchairs, they handled the person gently and also talked to them. Staff covered them with a blanket to ensure their dignity.

We saw other instances of staff responding to people's needs. For example, a person was preparing to stand up. A staff member put the persons walking aid by them to support them. A person indicated that they were cold. A staff member immediately got them a blanket and a portable heater so that they were provided with more warmth.

A staff member asked a person if they had any pain when supplying them with their medicine. This was to ensure that they could be given pain relief medicine to respond to their condition.

However, a relative said that staff did not always respond to his family member's needs. For example, his relative had been found unshaven on a number of occasions. The acting manager stated the person had refused assistance to shave. He said he would follow up issues with the relative and we saw evidence that a meeting was arranged to discuss and deal with any issues the relative had.

Staff told us they were informed of any changes to people's needs during a 'handover' meeting in the morning and each time there was a new shift. This meant they had up-to-date information on people's needs in order that they could to provide people with responsive care and support.

We looked at care plans for four people using the service. People's needs had been assessed prior to them moving to the service. The information gained from these assessments was used to develop care plans to aim to ensure that people received the care and support they needed. Information was detailed about activities of daily living such as how to communicate with the person, personal hygiene and, eating and drinking needs. There was evidence that care plans have been reviewed to ensure that support was available to meet peoples changing needs.

There was also information about people's interests and lifestyle preferences. When we spoke with staff about people's needs and interests, they were familiar with them and were able to provide information about people's likes and dislikes.

Care plans were seen to be in place and were reviewed to ensure that care was still appropriate to meet peoples' needs.

Staff told us that they had not read all the care plans of people living in the service, though they had been informed about people's care needs. Not having read all the information in people's care plan, this told us that management had not ensured that staff had read care plans to be in a position to respond to all of people's needs. After the inspection, the acting manager sent us an action plan stating that action would be taken to ensure that staff would be fully aware of people's care plans.

People told us there were not always sufficient staff on duty to meet people's needs. Some people told us that help to support them to the toilet bathroom was not always prompt. Sometimes the wait was up to 45 minutes. Staff also told us that there were not enough staff on duty to be able to respond to people's needs quickly and that they did not have time to spend talking to people on a one-to-one level, as people wanted. They said that they had spoken with the previous registered manager and the current acting manager about this. They said they were informed that the provider did not think that higher staffing levels were needed. The acting manager said that staff had not provided evidence suggesting that current staffing levels were insufficient to respond to people's needs. We pointed out that it was the management responsibility to ensure that staffing ratios were sufficient to meet people's needs. On the staff rota we saw, staffing levels declined from 3pm when there were only three care staff available to meet the needs of 35 people. This indicated that staffing was not sufficient to comprehensively respond to people's needs.

The Provider Information Return stated that approximately 80% of people were living with dementia and the same ratio of people had dependency needs, which meant that two staff were needed to provide personal care to one person. We asked the acting manager what staffing formula was used to calculate staffing levels that could respond to people's needs. He stated there was no set formula in place. He later sent us a formula but this did not contain detailed information which related to how people's needs were fully responded to.

Relatives told us they were able to visit regularly and were always welcomed by staff. This showed that people were supported to maintain contact with people who were important to them.

People told us there were was a variety of activities such as musical bingo and quizzes. Religious festivals were celebrated and staff encouraged people to dress up accordingly and cook a different meal during each festive period. There was a Christmas party and people helped to decorate the home. Local school children visited and sang Christmas carols.

We saw evidence of weekly organised activities to provide stimulation to people such as games, share this story, skittles, exercise to music, memory and scrapbook time and crafts. However we observed no activities on the day of the inspection visit. Staff told us that there were activities such as religious chanting, talking to people about their lives, walking, and colouring. We also saw records where people's activities were recorded. However, this was limited and recorded day-to-day events such as people speaking to each other or watching the TV. This meant people had not been given frequent opportunities to receive stimulating activities.

We spoke with staff who told us of different activities throughout the week. These included singing, music and movement and trips out. There was also evidence that people had one-to-one time with staff. The acting manager acknowledged that there was a lack of evidence of the provision of frequent activities. He indicated that he would look at enrolling a staff member on specialised training to provide appropriate activities to people living with dementia.

We looked at the complaints and suggestions book which contained a small number of complaints. This included general details of the action proposed to resolve the issues raised, but no specific indication of how and when this would be done. For example, there had been one complaint about a strong unpleasant odour in a corridor. The response has been that these things can happen in an instance and that there were checks in place. The complainant may not have been satisfied with this explanation, as the response did not appear to meet the substance of the complaint. The acting manager stated proper, detailed responses would be put into place for any complaints made. This would then indicate that the management of the service fully listened to and learnt from people's experiences, concerns and complaints.

The provider's complaints procedure did not set out the role of the local authority in undertaking complaints investigations if the person was not satisfied with the action taken by the provider. There was information about the local government ombudsman but the procedure incorrectly stated this service should be contacted if the complainant was not satisfied with the homes investigation. It did not state the local authority's role in investigating the complaint. The acting manager said the procedure would be amended and later sent us information indicating this had been carried out.

Requires Improvement

Is the service well-led?

Our findings

It is a condition of the registration of the service that it has a registered manager in place to manage the service. At the time of this inspection visit, the previous registered manager had left three months previously. The acting manager told us that the recruitment of a new registered manager had been held up due to refurbishments in the service. He provided evidence after the inspection that an advert had been placed to recruit another registered manager and stated that people had already expressed an interest in applying for the post. We queried whether the recruitment into this post needed to have been delayed due to refurbishment. We expect an application for this post to be made in the near future. Failing this, we will consider taking regulatory action to ensure this condition of registration is met.

The quality assurance policy of the service stated that the company "recognises the fundamental importance of quality assessment and monitoring." There was evidence that some quality assurance systems were in place. These included audits looking at health and safety, maintenance checks, of the premises and medicine. However, when we toured the building, we found beds had not been properly made with bed sheets crumpled and there were crumbs and pieces of tissue in some beds. Monitoring had not properly identified and rectified this issue. Audits of the premises had noted issues that needed action but not whether this had been carried out. For example, in the audit of 1 November 2016 the audit stated that a toilet seat needed replacing, a sink was dirty and a door was not closing properly. However, no action was recorded as being taken to rectify these issues. This does not indicate a well led service.

We saw evidence of medicine audits undertaken. However, the last one had been carried out in April 2016, over seven months previously, and had only included whether there had been the correct amount of medicine in place, not other issues with regard to the ordering, administration, disposal of medicines and whether staff training had been sufficient to ensure a safe system. The acting manager said regular and detailed medicine audits would be undertaken.

There were no systems in place for important issues such as staffing levels, staff recruitment, staff supervision infection control, observation of care practice by staff, care planning, fire checks, the premises, maintenance checks and protecting people's skin from pressure sores. Some audits had been set up, for example the "care file audit", a health and safety audit and an infection control audit, but these records were blank and audits had not been carried out. The kitchen audit of May 2016 noted some issues that needed following up such as cleaning and required notices not being correctly displayed. However, there was no record to indicate that action had been taken.

By having comprehensive quality assurance systems in place, this would protect the safety and welfare of people living in the service. It would also have meant that the issues identified in the breach of regulation at the last inspection would have been rectified. This is not an indication of a well led service.

This was in breach of regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. You can see what we have told the provider to do at the end of this report.

Some of the people and their relatives we spoke with were not sure who the acting manager was. People said that due to the language barrier they could not communicate with the acting manager. We observed the acting manager asking people how they liked the food. However, due to the language barrier there was only very limited conversation possible.

We observed that the acting manager did not know the names of the people and their relatives and was not able to speak in detail with them about their experience of the care in the service. A relative told us, 'It would be nice if the manager could remember the resident's names, which feels more personal and comfortable to them."

A relative told us they were glad to see facilities had improved with the refurbished bathrooms and lounges. They thought these changes would improve people's well-being.

However, another relative told us that they did not think the service was well run. They said there had been issues with medication, lack of activities and lack of personal care for their relative. The acting manager said that there had been an issue with medicines as the person had been newly admitted and had a different pharmacist and the relative had to be involved to obtain medicines. The person had also refused personal care and this was why they were unshaven. We saw the acting manager then arranged a meeting with this relative to investigate their concerns further.

Staff told us that the acting manager was friendly towards them but as he could not speak their first language, he was not proactive in managing the service, and they had to rely on other senior staff to manage. The acting manager conceded that it was not easy to manage the service without the ability to speak the main language of people and staff.

Staff told us they could approach the management team about any concerns they had. One staff member said, "If I need help, I go to the office and I get it." Another staff member said, "There is support if we need it." However, one staff member said that a member of the management team had shouted at her and did not respect her. This was reported to the acting manager who informed us after the inspection he had followed up this issue.

Staff members we spoke with told us that the management team expected people to be treated with dignity and respect. They said they would recommend the home to relatives and friends because they thought the interests of people living at Vishram Ghar were always put first.

We saw that residents meetings had taken place. Staff we spoke with told us there had been regular team meetings where they had discussed any changes in the service or any particular issues and concerns with people and their relatives. This meant people had the opportunity to be consulted about the services offered and they had been included in the running of the home.

Staff said that essential information about people's needs had always been communicated to them by way of daily handovers, so that they could provide appropriate care that met people's needs.

People had been asked their opinions of the service in the past year by way of completing satisfaction surveys. This showed that people's experience of living in the home had largely been positive and they had been asked whether this could be improved. However, there were some issues raised such as poor maintenance, windows being unclean, lack of activities, and requesting an emergency buzzer for each person to alert staff to their needs. However, there was no action plan in place to take these issues forward and no evidence that they had been acted on. The acting manager said this issue would be followed up.

Staff had support through having regular staff meetings and we saw minutes of these meetings. These covered relevant issues such as the cleanliness of the service, reporting safety issues and management expectations as to how to provide effective individual care to people. Staff told us that they could raise issues and suggestions at these meetings, which had been discussed. We saw evidence that staff had been complimented on supplying good care to people living in the service. This showed that staff received recognition for their efforts in meeting the needs of people, which helped to maintain their morale.

We saw evidence that aspects of the premises had been improved, such as decor in ground floor lounges and corridors and refurbishment of toilets and bathrooms. We found some worn furniture in the first-floor lounge. The acting manager said within two months, furniture would be replaced and there was a rolling programme of redecoration for people's bedrooms.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had not been protected from risks to their safety with respect to safe personal care provided, staffing levels not being sufficient to ensure their safety, systems to alert staff not fully in place, no systematic monitoring of potentially unsuitable staff and the risk of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was no registered manager in place, which is a condition of registration. The breach of the regulation in the last inspection to have effective quality assurance measures in place had not been comprehensively followed up.