Karuna Care (TLC) Limited

Karuna Manor

Inspection report

Christchurch Avenue
Harrow
Middlesex
HA3 5BD

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19 May 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 May 2016 and was unannounced. Karuna Manor is a care home registered to provide accommodation for people who require nursing or personal care. They are registered to provide care for a maximum of 60 people who may be living with dementia. There were 21 people using the service at the time of our inspection. This was the first inspection for Karuna Manor since their registration in March 2015.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the day of the inspection we observed that people were well cared for and appropriately dressed. People who used the service said that they felt safe in the home and around staff.

Relatives of people who used the service and care professionals we spoke with told us that they were confident that people were safe in the home.

People were not adequately protected from the risks of unsafe medicines management. Medicines records were not kept up to date so we could not be certain that people were adequately protected from the risks of unsafe medicines management. We found a breach of Regulations in respect of this.

On the day of the inspection staff were not rushed and were able to complete their tasks. However, feedback from people, relatives and staff indicated that at times, there were not enough staff in the home to care and support people safely. This could risk people receiving inconsistent and inappropriate care.

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

People's care needs and potential risks to them were assessed. However there was limited information about the moving and handling needs of people using the service and the safety of bed rails in the home. We discussed this with he registered manager who told us he would ensure all the bed rails were checked and appropriate training would be provided to staff. He also told us risk moving and handling risk assessments for people would be reviewed.

Staff prepared appropriate care plans to ensure that people received safe and appropriate care. Their healthcare needs were closely monitored and attended to. Staff were caring and knowledgeable regarding the individual choices and preferences of people.

There were records of essential inspections and maintenance carried out at the home. The service had an infection control policy and measures were in place for infection control.

Staff had been carefully recruited and provided with induction and training to enable them to support people effectively. They had the necessary support, supervision and appraisals from management.

People's health and social care needs had been appropriately assessed. Care plans were person-centred, detailed and specific to each person and their needs. Care preferences were documented and staff we spoke with were aware of people's likes and dislikes.

People told us that they received care, support and treatment when they required it. Care plans were reviewed monthly by staff and were updated when people's needs changed. However, there were some gaps and inconsistency in the monitoring of people's care on a daily basis.

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

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The home had made necessary applications for DoLS as it was recognised that there were areas of the person's care in which the person's liberties were being deprived. Records showed that some authorisations had been granted and some were awaiting approval from the local authority.

People's spiritual and cultural values were fully respected and accommodated. The home provided vegetarian food in accordance with people's culture. People were able to watch Indian programmes on television. Care staff were able to speak in Hindi and Gujarati which meant they were able to effectively communicate with people using the service. There was a Mandir (Hindu Temple) on the ground floor and people were supported and assisted to do their prayers and Bhajan (hymns) in the morning.

Staff were informed of changes occurring within the home through daily handovers and staff meetings. Staff told us that they received up to date information and had an opportunity to share good practice and any concerns they had at these meetings.

There was a management structure in place with a team of care staff, nurses, kitchen and domestic staff, admin manager, registered manager and the provider. A clinical services manager had also been recently recruited. Staff had a positive attitude and were of the opinion that the service was well managed and the registered manager was supportive and approachable.

There were some quality assurance processes in place to assess and monitor the quality of service being provided and action had been taken. However, there was no effective evaluation of the issues identified. During this inspection, we found further concerns which demonstrated the current systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people. We found a breach of regulations in respect of this.

We made two recommendations about moving and handling and seeking advice and guidance from a reputable source about adjustments required to meet the needs of people living with dementia.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe. The current processes did not ensure the proper and safe management of medicines which places people at risk of receiving their medicines incorrectly

Feedback from people, relatives and staff indicated at times, there were not enough staff in the home to care and support people safely.

Risks to people were identified and managed so that people were safe and their freedom supported and protected. However there was limited information about the risks of unsafe moving and handling practices.

People who used the service and relatives we spoke with said that they were confident the home was safe.

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

Is the service effective?

Good

The service was effective. Staff had completed training to enable them to care for people effectively. Staff were supervised and felt well supported by their peers and the registered manager.

People were able to make their own choices and decisions. Staff and the registered manager were aware of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and the implications for people living in the home.

People were provided with choices of food and drink. People's nutrition was monitored and dietary needs were accounted for.

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

Is the service caring?

Good

The service was caring. We saw that people were treated with kindness and compassion when we observed staff interacting with people who used service. The atmosphere in the home was calm and relaxed.

People were treated with respect and dignity. Staff respected people's privacy and dignity and were able to give examples of how they achieved this.

Wherever possible, people were involved in making decisions about their care. Care plans provided details about people's needs and preferences. Staff had a good understanding of people's care and support needs.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Accurate and contemporaneous records about people's care and support were not being kept or effectively monitored.

Care plans were person-centred, detailed and specific to each person's individual needs. People's care preferences were noted in the care plans.

The home had a complaints policy in place and there were procedures for receiving, handling and responding to comments and complaints.

Is the service well-led?

Requires Improvement

Some aspect of the service was not well led. The current systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people.

There was a management structure in place with a team of care workers, nurses, kitchen and domestic staff, admin manager, registered manager and the provider. A clinical services manager had also been recently recruited

Staff felt they were supported by the registered manager and their peers.

Karuna Manor

Detailed findings

Background to this inspection

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

The inspection team consisted of two inspectors, a pharmacy inspector, a specialist advisor and 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

Before we visited the home we checked the information we held about the service and the service provider including notifications and incidents affecting the safety and well-being of people. No concerns had been raised.

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

During the inspection, we spoke with twelve people who used the service and five relatives. We also spoke with nine care staff, two kitchen staff, and two nurses. The clinical lead, quality manager and registered manager. We also spoke with two visiting healthcare professionals.

We reviewed six care plans, seven staff files, training records and records relating to the management of the service such as audits, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People we spoke to generally told us they felt safe at the home. They told us, "It's good living here. I feel safe" and "Yes, I do feel safe." One relative told us, "I know [person] is safe here."

We found there were arrangements in place to manage people's medicines. However some medicines records were not kept up to date when people's medicines were changed so we could not be certain that people were adequately protected from the risks of unsafe medicines management.

There was evidence of personalised timing of medicines, so people received their medicines at times that suited them. We observed a medicines round, and saw that people were treated kindly and were not rushed when staff were administering their medicines to them. Falls risks due to medicines were considered. The home's falls risk assessment included two questions on falls risks due to medicines

Medicines were stored securely in all three of the clinical rooms, which were clean, spacious and well ordered. Medicines requiring storage at room temperature were kept at safe temperatures. Controlled drugs were stored according to legal requirements, stock balances were checked every day, and accurate and up to date records of use were kept in a controlled drugs register.

For people on oral medicines for diabetes, diabetes care plans were in place, there was evidence that people's blood glucose was monitored regularly, at the frequency specified in their care plans, and there was guidance in place for staff on the action to take if someone's levels were too high or too low. Emergency glucose gels were available for the treatment of low blood glucose, and emergency bags contained blood glucose monitoring equipment were now available in each clinical room on each floor. These were put in place after a recent incident when blood glucose monitoring strips could not be located in an emergency.

The GP visited the home weekly, and there was evidence that staff contacted the GP promptly when people's medicines needed to be reviewed. A form was in use "Important mid cycle changes to peoples medicines" to document any changes to people's medicines, and there was information about medicines on people's "Medical condition and medication care plan", although these were not always updated when people's medicines were changed.

Prescribed creams were kept safely in people's rooms and were in date. Instructions were provided to health care assistants on how often and where to apply the creams. Records were kept when these were applied.

There was a supply of over the counter (OTC) medicines to be used for minor ailments to avoid calling out the GP unnecessarily and these had been authorised for use by the GP for each individual person. The registered manager told us that occasionally people's families brought over the counter medicines and creams into the home and asked care staff to administer these. The registered manager was going to put a procedure in place to enable this to happen once the OTC medicines had been confirmed as safe to use by the person's doctor.

Most of the people living at the home relied on staff to administer their medicines to them, as they were unable to self-administer. Arrangements for ordering medicines were effective, and all prescribed medicines were available. Medicines administration records (MAR) were completed clearly, including information about people's allergies, and there were no gaps or missed doses. This provided assurance that people were receiving their medicines as prescribed.

However, when we checked the MARs against people's current prescriptions, two out of the ten MARs on the nursing floor contained incorrect instructions for administration. One person's diuretic medicine appeared twice on their MAR, and had been signed for as if it had been administered twice in error. The instruction on another person's MAR was for three times a day administration of an iron supplement; however this was prescribed to be given twice a day. Prior to our inspection, another person had almost received an incorrect medicine as the GP had made a prescribing error and the home's internal checking processes for medicines had not picked this up. Although none of these people had received their medicines incorrectly, the checking process to ensure that instructions on the MAR were accurate before being used to administer medicines to people was not robust enough, so this had placed people at risk of receiving their medicines incorrectly.

We saw that some other medicines records were not kept updated when people's medicines changed, such as self-administration care plans, protocols for "when required" medicines, covert administration care plans and "Medical condition and medication" care plans. Not keeping these up to date had not resulted in any errors, however not updating medicines records and care plans promptly increases the risk of a medicines error as staff are not provided with the most up to date information about people's medicines.

Whilst staff recorded the medicines fridge temperature on a daily basis, they did not record the minimum and maximum temperatures of the medicines fridges, therefore it was not possible to establish whether medicines needing to be stored between 2-8C were kept at the correct temperatures to remain safe or effective to use.

Arrangements were in place to dispose of medicines and sharps however one pain-relieving medicine had been administered to someone one month after the expiry date. There was no evidence that the site of application of pain-relieving patches was being rotated every 3-4 weeks, according to the manufacturer's instructions, which may have placed two people at risk of side effects.

Although there were protocols in place for the administration of medicines that were prescribed to be given 'as required' (PRN), these were not detailed enough. For example the PRN protocols for pain relieving medicines did not specify what sort of pain these were for, or whether staff needed to carry out an assessment of someone's pain. For people prescribed more than one type of pain relief, the protocol did not specify in which order to try these pain medicines, or whether it was safe to give them at the same time. When the doctor had changed the dose of PRN medicines, the protocols had not been updated. This meant that some people might be at risk of not receiving their PRN medicines such as pain relief when they needed them, and as intended by the GP.

Although the home had a procedure to administer medicines covertly when people did not have capacity to consent to taking essential medicines, this was not always followed. The MAR for one person included an instruction to crush this person's tablets, however we could not find any authorisation for this, and the "record of decision to administer medicines covertly" had not been filled in. For another person who was receiving their medicines in food, the "record of decision to administer medicines covertly" had been completed, however the pharmacist had not been consulted, to advise whether the method of covert administration was safe. A new medicine was being administered covertly which was not listed on the covert

decision record, so was not authorised to be given covertly. There was an instruction on another person's medicines record that medicines were to be given with yoghurt or food, but there was no record that advice had been sought on whether this was safe, and whether these medicines were being administered covertly or because of swallowing difficulties.

One person was being supported to self-administer one of their medicines. This had been risk-assessed as safe and the person was provided with a lockable cupboard to store their medicines safely. We noted that although the agreement was just for one medicine, the person was now self-administering two additional medicines.

All members of staff with responsibilities for medicines, including Health Care Assistants, had received medicines training and had their medicines competency assessed. One member of staff had recently made an error, and we saw that they had been taken off medicines duties until they had been reassessed as competent. As we noted some issues with medicines, this training was not completely effective. The registered manager told us he had plans to reassess medicines competencies for staff.

The above evidence demonstrates the current arrangements in place did not ensure the proper and safe management of medicines which places people at risk of receiving their medicines incorrectly. People were not adequately protected from the risks of unsafe medicines management.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the staff rota and discussed staffing levels with the registered manager. On the day of the inspection there were a total of 21 people who used the service. The home has three floors and staffing levels usually consisted of three care workers on the ground floor, four care workers supported by a nurse on the first floor and two care workers on the second floor. During the night shifts there were two care workers on the ground floor, three care workers and a nurse on the first floor and one care worker on the second floor. In addition, the home had kitchen and other household staff.

On the day of the inspection the atmosphere was calm in the home and staff were not rushed. We observed people had calls bells in their rooms which were accessible. However, we received mixed feedback from people using the service, relatives and staff who felt there were not enough staff. One person told us, "When I ring they come quickly." However, six people told us "There is not enough nursing care on this (first) floor. The nurse is sometimes called downstairs", "I wait sometimes 15 minutes for the bell to be answered and once, when they came they said crossly 'Enough! Enough!", "I think they need more staff because sometimes you ring and sometimes they take 10 minutes to come" and "When I ring the bell, they say, 'You are not the only one here!", "They don't come quickly if I ring the bell. 'Do you know we are eating?' they said to me once" and "It takes a little longer for the bell to be answered at night."

When speaking with one person, they told us about an incident where there was a delay of 10 minutes from the time they requested for assistance to go to the toilet and the response of the staff. Although one staff came immediately, she could not respond to the needs of the person because she needed the assistance of another staff. The person was very annoyed at the time taken. The person did however say, "The staff are very good and kind and I am very well looked after."

Records showed this was documented in the notes. The entry was entered by a care worker, but not countersigned by the nurse as required. When we spoke to the nurse and the registered manager they were not aware of this incident and only became aware of it when we brought it to their attention. We noted daily

records were not always countersigned by the nurse. In some entries the spelling was poor and had not been corrected. This would indicate that the care given by care staff was not always being monitored which could risk people receiving care and support which was inappropriate and unsafe.

When we spoke to the registered manager, he was not aware of the incident but told us he would look into the incident and the lessons learned will be shared with the other staff.

We noted records dated 17/4/2016, there was an incident recorded that there was no member of staff found on the first floor. It was then discovered that the floor was being covered by only one staff member. The staff member who was on night shift had left without doing a handover and ensuring there was staff available to cover the floor. The registered manager told us they had taken action and disciplined the staff member involved.

One relative told us, "Usually there is enough staff but at the weekends they are short of staff. You have to look for somebody when you need them. The reception area is not manned after seven although the outside door is locked."

Feedback from staff also indicated that the staffing levels may not be adequate. They told us "We work together as a team. It would be good to have one more person here. When we need to use a hoist, two of us are needed. People like to go to bed at different times, some like to take a nap in the afternoon and we need to help them with that. Sometimes the whole day, it's like that", "We are coping but if we get more people in the home, then it will be difficult. People can be very demanding and want you there straight away at all times. Some people have two showers a day. It is hard. If they want this level of care and attention, they need to raise the staffing in the home", "Sometimes we can't cope" and "One nurse can't manage everyone. 2 nurses would be good. When relatives know I am here they come and talk to me about their relatives. They don't talk to the nurse as it's always a different nurse when they come."

We discussed the staffing levels with the registered manager and that depending on people's needs, two care workers may be required at one time which could leave floors left with inadequate cover should another person call for assistance or for general supervision of the floor. We were informed that the levels had been reviewed according to people's needs and the home had sufficient staff deployed to meet the needs of people. The registered manager also told us they had bank staff that were able to help if needed.

We also spoke of our concerns that there was only one nurse available for 21 people some of whom require nursing care and the number of concerns we found with the management of medicines overall. Some of the nurses were agency nurses which could risk inconsistency in the care and support people received. This may not also be adequate in an emergency situation which may place people at risk. The registered manager told us that there were senior care workers that support the nurse and were able to administer the medicines. They agreed to review staffing levels as occupancy increases.

People's care needs had been assessed. Care plans we reviewed included relevant risk assessments, such as the Malnutrition Universal Screening Tool (MUST) risk assessment, used to assess people with a history of weight loss or poor appetite. Pressure ulcer risk assessments included the use of the Waterlow scoring tool and falls risk assessment. It was evident that the service had identified individual risks to people and put actions in place to reduce the risks. These included preventative actions that needed to be taken to minimise risks as well as measures for staff on how to support people safely. Risk assessments were reviewed monthly and we saw documented evidence that these were updated when there was a change in a person's condition.

However, we spoke with two relatives who had concerns about the way manual handling was conducted in the home concerning their relatives in the home and they felt that their feedback to staff had not been taken on board. They told us, "We have concerns about training: getting [person] up from the chair. [Person] is being asked her to hold onto the walking frame to help himself up. This is difficult for [person] and the physio at home said [person] should push himself up and down using the arms of the armchair. We've shown the staff here how [person] should do this but we still find them not doing it this way. Things like that should be fundamental. They should know care-handling and it's a cause of concern. We've told [registered manager] several times and also the carers and the nurse but they are still not getting it right."

The registered manager told us there was a moving and handling train the trainer member of staff on site and staff were shown what to do in the home. When we spoke to care staff, they confirmed this was done face to face and they were shown what to do. However we noted that people's care plans contained limited information about people's moving and handling needs and how this was to be done. For example, in one person who used a zimmer frame, there was no specific information about how to assist with personal care in terms of their mobility.

Records showed that bed rails risk assessments were in place and the checks indicated that hourly bed rails checks were maintained. People's care plans also contained a 'Use of bed rail care plan' which detailed their requirements in this area. For example in one care plan it stated, "[Person] only likes to have the right side bedside rails to be used whilst in bed so that they can go to the toilet by the left hand side of the bed. [Person] also uses the right side bedside rails to hold to reposition or get up from the bed."

However measurement of the effectiveness of the rails when air mattresses were used were not always carried out. When we enquired about this from the agency nurse, she told us, "I have my own measurement for the rails and it is in my car". There was no instrument on the floor to measure the gaps to ensure the safe use of bed rails. In another room the bed rails were not in use and was not secure. A moving and handling risk assessment for one person stated that the person uses bedrails and bumpers. Although the potential hazards associated with this had been identified there was no detail about what action staff should be aware of to the mitigate risks and ensure the person was supported safely. Staff told us that they had not received any training in the use of rails. The registered manager told us he would ensure all the bed rails were checked and appropriate training would be provided to staff. He also told us risk moving and handling risk assessments would be reviewed.

We recommend the service review moving and handling needs for people using the service and seek advice and guidance from a reputable source about effective moving and handling and bedrails management.

As part of the inspection we looked at how skin integrity of people who used the service was managed. We saw evidence that those people who had been assessed to be at high risk of developing pressure ulcers based had measures in place to prevent them from developing pressure ulcers. For example, for one person in their care plan there was a wound management booklet. The booklet consisted of initial care assessment, pressure sore classification, wound care treatment chart, wound assessment and evaluation, pain assessment tool and monthly wound care checklist and a risk assessment.

Records showed that all the relevant documentation had been completed as per instructed and staff had acted on what they had recorded they would do. It showed that the wound was checked on a regular basis, the site cleansed on a regular basis and cream applied as prescribed. The person was managed on an air-mattress with cot-side and repositioned regularly. The entry indicated that the wound was improving. The person told us, "My wound is healing, I know because I am not in pain and they reposition me in bed every 2/3 hours and they sat me in a chair once a day. I have a bath daily and when I need to go to the toilet they

wash me. The staff are very good". The person also told us that they did not require pain killers as often and the staff ask whether they were in pain on a regular basis.

Air-mattress pressure were checked and recorded regularly. The staff were knowledgeable about the pressure that should be maintained for different people. They also knew how to respond if the air mattress were faulty. One care worker told us that she would move the person to another bed with an air-mattress with the appropriate pressure. We saw the home had a stock of air-mattresses available.

Records showed the fire alarm was tested to ensure it was in working condition. The last fire drill was carried out on 3 March 2016. The home had a fire risk assessment and a general evacuation plan. All the residents had a Personal emergency and evacuation plans (PEEP) plan in place in case of fire.

There were safeguarding and whistleblowing policies in place and records showed care workers had received training in how to safeguard adults and were aware of actions to take in response to a suspected abuse. When speaking with care staff, they were able to explain the different types of the abuse and the steps they would take if they suspected any potential abuse.

We looked at the recruitment process to see if the required checks had been carried out before staff started working at home. We looked at the recruitment records and found comprehensive background checks for safer recruitment including enhanced criminal record checks had been undertaken and proof of their identity and right to work in the United Kingdom had also been obtained. Two written references had been obtained for staff.

Good

Is the service effective?

Our findings

Staff told us that they felt supported by their colleagues and management. They were positive about working at the home. They commented on the good team spirit amongst staff, good knowledge and skills possessed by all staff in the home which had helped to maintained a good working standard in the home. Staff told us, "It's good working here. We work together as a team. I am happy here" and "It's fine working here. I feel supported. The manager comes to the floor and asks how things are."

Staff had the knowledge and skills to enable them to support people effectively. We saw evidence that staff had undertaken an induction when they started working at the service. There was evidence that staff had received regular supervision sessions and this was confirmed by staff we spoke with. Supervision sessions enabled staff to discuss their personal development objectives and goals. We also saw evidence that staff had received an annual appraisal about their individual performance and had an opportunity to review their personal development and progress.

Training records showed that staff had completed training in areas that helped them to meet people's needs. Topics included medication awareness, COSHH, Equality and Diversity, Fire Prevention and Awareness, Infection control, food hygiene, dementia awareness, mental capacity and DoLs, manual handling and health and safety. Staff spoke positively about the training they had received and were able to explain what they had covered during the training sessions. There was a training matrix in place which clearly showed what training staff had completed and when the next refresher was due. This ensured staff's training was being monitored to ensure staff received the appropriate training.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We noted that care plans contained some information about people's mental state and cognition however no comprehensive mental capacity assessments had been carried out. Areas in which a person was unable to give verbal consent, records did show the person's next of kin and health professionals were involved to ensure decisions were made in the person's best interest.

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

People had their healthcare needs closely monitored. Care records of people were well maintained and contained important information regarding medical conditions, behaviour and any allergies people may have. There was evidence of recent appointments with healthcare professionals such as people's dentist, optician and GP. Information following visits by GP and other professionals were documented in people's records. Three people using the service told us that the doctor visited weekly. One person told us, "I saw him yesterday, he comes weekly." Two people told us they were pleased that their own doctor visits them in the home and commented "My own doctor comes to visit me if I ask the nurse to arrange it."

Care records showed that nutritional needs of the people who used the service were assessed. Where people had a low weight and a low body mass index, we saw that the service had referred them to the dietician or GP for advice and were monitoring their progress. People's weights were recorded monthly so that the service was able to monitor people's nutrition and there was detailed information about people's nutritional needs.

People spoke positively about food at the home. One person told us, "The food is good." During the inspection we spoke with the chef about the food prepared in the home. She was knowledgeable of people's dietary needs and preferences and told us that all the food prepared in the home was freshly prepared daily. The home had a weekly menu and it included a variety of different types of Asian foods. The food provided at the home was all vegetarian as everyone in the home was vegetarian. There were alternatives for people to choose from if they did not want to eat what was on the menu.

During the inspection we observed people having their lunch, which was unhurried. The atmosphere during lunch was relaxed. Dining tables were laid attractively and people sat at tables with one another and were able to engage with staff and people who use the service. We observed that meals were presented attractively. Staff took care to offer people choices about what they wanted. People were offered water, juice and teas and coffees during the meal. Staff were attentive and created a pleasant atmosphere chatting with people over lunch. We saw that people who were supported to eat were helped in a respectful manner with staff sitting next to them, and taking the time required to help them to eat.

For example, one care staff who was feeding a person was very careful to ask them about what food they wanted next (we observed there was a selection on their plate) and asked how they were enjoying it. She regularly offered the person a drink and her manner was empathetic and patient. One person who had lost interest in eating was noted and joined by a member of care staff who sat beside the person and tempted them patiently with occasional spoonfuls until the person regained interest in their food.

The kitchen was clean and we noted that there were sufficient quantities of food available. We checked a sample of food stored in the kitchen and found that food was stored safely and was still within the expiry date. Food in packaging that had been opened was appropriately labelled with the date it was opened so that staff were able to ensure food was suitable for consumption.

People receiving end of life care had the appropriate plans in place. We reviewed the care of one person and found this was managed effectively. The person' care plan showed the wishes of the person and involvement from their family was documented. The GP visited weekly. There were clear guidelines for staff about how they should act if the person's condition deteriorates.

In addition there were care-plans covering all aspects of the person's daily living including the management of pain. The person was on oxygen and this was monitored regularly. We observed the staff implementing the feeding care-plan which involve input from the speech and language therapist and district nurse. The staff had purée food by the bedside, the staff explained and encouraged the person to eat, giving a small bit

at a time with a moist cloth by her side. The staff told us, "We take our time whilst attending to the feeding because [person] does not have much of an appetite". Fluid and food were in place to monitor input and output. We noted the person's favourite mango drink was provided.

There was a care plan to check and maintain skin integrity. The person was on an air-mattress and the pressure was monitored regularly. Bed rails were in use and checked hourly. The person was repositioned three hourly and regularly. There was a pain management plan in place and this was adhered to. The person had the call bell near them. The room was clean and tidy. The person had clean clothes. The bed linen appeared fresh and there were photographs of the persons relatives nearby. The staff told us that the person likes talking and we pop in all the time.

There was evidence of close working with the palliative care team. Anticipatory medicines were already available for the treatment of pain and other symptoms for people who were nearing end-of-life, to avoid delays in starting treatment. We spoke with a visiting healthcare professional who spoke positively about the end of care provided at the home. They told us the home linked the palliative care nurse and the GP and they usually do this effectively and that they provided good end of life support.

Records showed that some people had "Do not attempt cardiopulmonary resuscitation" (DNACPR) forms in place. We looked at eleven DNACPR forms and saw they had been signed by the GP. All the forms stated that this had been discussed with family members however nine of the DNACPR forms had not been signed by family members to show their involvement and agreement. The registered manager told us he would review the forms and ensure family involvement was correctly recorded and they were signed by them.

The registered manager showed us a list that was displayed on each floor which detailed the names of people and room numbers who had DNACPR forms in place. We also noted a discreet red 'D' was also placed on bedroom doors so staff were aware. Training records showed staff had received recent training in Basic Life Support and CPR. A number of staff have received supervision and practice on making a 999 call and dealing with an emergency. These were put in place after a recent emergency incident at the home.

The registered manager told us and records also showed that staff were allocated particular roles should an emergency situation arise. These included who would be responsible for calling the ambulance, doing the CPR if needed, retrieving the emergency and contacting the family. This was done daily to ensure staff were ready to deal with an emergency situation promptly and effectively.

We found the home was exceptionally clean and tidy and there were no unpleasant odours. The service had an infection control policy and measures were in place for infection control. The home had separate cleaning staff allocated for cleaning responsibilities. A cleaning schedule was in place to ensure that the home was kept clean and regularly monitored. Staff we spoke with had access to protective clothing including disposable gloves and aprons. People's bedrooms were clean and there was no smell in the home despite people having incontinence needs. This indicated good incontinence management. Used pads were disposed appropriately. One staff told us "The soiled pads are disposed immediately and this prevents bad odours and also the residents are given a wash after they are incontinent and the pads changed regularly."

We observed reasonable adjustments had been made in the home in response to people's specific needs. For example, there were hoists and bath and shower equipment available to assist with people's needs and a lift in the home to support people with their mobility. The home was well lit and furnished to a high standard. There were some adjustments for meeting the needs of people with dementia. The rooms were personalised with identity boxes and there were memory boxes outside each room to enable residents to identify their rooms. On the second floor, we noted that the floor was for people with dementia, however

this floor looked identical to the other floors. There was no signage, contrasting colours and pictures that could help people with their memory but also help people to recognise and navigate around the home. The registered manager told us he would look into reviewing this for the second floor.

Good

Is the service caring?

Our findings

People using the service and relatives told us that the staff were very kind and caring. They told us, "They always asked you how you want to be called", "They show respect for old age in the way they address you" and "Over here they do everything for you."

We observed respectful and caring interactions between care staff and people who used the service. For example, one care staff member noticed that a person was sitting awkwardly and came across the room to adjust their legs so that the person was more comfortable. She spoke with the person first about this so that the person consented and understood what she was doing. Another carer was helping a person move from a chair in the lounge to the dining room via a wheelchair. The care staff member crouched down to make good eye contact and, again, the care staff first greeted the person and spoke with them about what she was about to do.

Staff were attentive and talked in a gentle and pleasant manner to people. Care staff smiled and asked people how they were. People responded by either smiling or nodding. People appeared to feel comfortable and at ease in the presence of staff. One person told us, "I talk to the carers about myself and they know me."

People and relatives spoke positively about the care workers and told us, "I can talk to any of the carers; they make time to talk to me", "The staff are cooperative", "The staff are respectful" and "I am friends with everybody." One relative told us, "[Person] is really happy and has friends here."

One care professional told us that they were confident that people were well cared for in the home and said that they had no concerns regarding this. Another healthcare professional told us staff treat people with respect. However, this healthcare professional did say that there was a high staff turnover which they thought was because of high demands placed on them. They told us staff worked hard, the facilities were very good and the food was very nice.

All bedrooms were for single occupancy and had ensuite facilities. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as photographs and ornaments, to assist people to feel at home. The home accommodated the needs of a married couple who we saw had a room of their own with two beds and a separate sitting room exclusively for their use.

Staff had a good understanding of the importance of treating people as individuals and respecting their dignity. During the inspection, we observed care workers entering people's rooms. On each occasion they knocked on the door and called to the person before walking into the room. They also understood what privacy and dignity meant in relation to supporting people with personal care. One staff member told us, "We always knock on the door. Inform them of what we need to do and explain what we are doing as we are going along. We give people choice like what they want to wear and how they want to be washed."

During the inspection, we observed people's spiritual, cultural, spiritual values were fully respected and accommodated for. The home provided vegetarian food according to people's culture. People were able to watch Indian programmes Bollywood films if they wished to. Care staff were able to speak Hindi and Gujarati which meant they were able to effectively communicate with people using the service. There was a Mandir (Hindu Temple) on the ground floor which enabled people to do their prayers and sing Bhajans(religious hymns) in the morning and evening. The home has a residential Hindu priest who showed us the temple and told us, "We do our prayers and Bhajan in the morning and evenings. All the Hindu customs we follow here. We also do gentle yoga here."

We observed people were supported and assisted to do their prayers and Bhajans in the morning. One person told us that it was good to have the priest in the home. This person said, "I am glad the priest is here all the time."

People were supported to maintain relationships with family and friends. One person using the service told us, "I keep in touch with my children and they can visit me anytime." During the inspection, we observed people had their own mobiles and phones in their bedrooms so they could contact their family members at any time. Relatives were observed visiting people and were able to spend time with them in the lounge areas and bedrooms. A visiting friend of a person told us, "I can phone any time and come any time. I am happy my friend is being looked after here" and a relative told us, "The environment is very welcoming. It's really good. They do speak to me about things."

People had the use of a quiet lounge on each floor which was comfortable and inviting. We observed people had free movement around the home and could choose where to sit and spend their recreational time. We saw people were able to spend time the way they wanted. Some people chose to spend time in the communal lounges and some people chose to spend time in their bedroom.

Requires Improvement

Is the service responsive?

Our findings

The service provided care which was individualised and person-centred. People and their family and representatives were involved in planning the care and support provided. People's needs had been carefully assessed before they moved into the home. These assessments included information about a range of needs including health, social, care, mobility, medical, religious and communication needs. Care plans were prepared with the involvement of people and their representatives and were personalised. Staff had been given guidance on how to meet people's needs and when asked they demonstrated a good understanding of the needs of each person.

Care plans provided detailed information about people's specific medical conditions. For example for supporting people with diabetes in the home, there was comprehensive and easy to understand information about diabetes in the care plans for people, staff and relatives. The information identified type 1 and type 2 diabetes, the signs and symptoms. There was also information on prevention, treatment and complications of the conditions.

There was a Diabetes policy in place. This policy was comprehensive and focused on a number of areas including the types of diabetes, who needs insulin, documentation, equipment and blood glucose monitoring. The policy also detailed how to deal with hypo and hyper glycaemia, administration of insulin, basic checks, sign and symptoms of hyper/hypo glycaemia and suggested improvements.

In one person's care plan, there was information about how to manage their diabetes. This included a risk management and regular monitoring of blood sugar. There were records indicating the involvement of the G.P, dietician, chiropodist and the chef. The chef told us, "We make our own sweets at the home, we don't use sugar. We use sweeteners for diabetes". There were weight charts and BMI charts. There was evidence that the physiotherapist and district nurse involved in the person's care.

We spoke with two members of staff and they told us that they had training on the management of diabetes and one care worker said, "The information that we have in the notes are easy to follow". One person told us about their diabetes and their general care and how it was managed. This person said, "I take tablets for the problem and they prick my finger daily, sometimes I get fed up about this, but it has to be done. I have problem with my eyesight and I have an appointment for cataract removal."

Care plans showed how people communicated and encouraged people's independence by providing prompts for staff to support people to do tasks by themselves. Care plans contained a night care plan for people which showed people's bedtime routine, their care regime before they sleep and whether they needed checking during the night. The care plans also detailed if people had any particular likes and disliked they enjoyed as part of their daily lives such as enjoying a particular drink in the evening or engaged in a particular activity such as playing cards. People using the service told us, "I like everything" and "It's all good here".

Care workers told us and records showed there was a handover after each of their shifts and daily records of

people's progress were completed each day. We saw the notes detailed the support people received, dietary needs, monitoring charts to complete, moving and handling and the general mood and well being of each person. Care plans were reviewed monthly by staff and were updated when people's needs changed. One care worker said, "The registered manager comes to the floor and asks how things are. There is a good handover in the morning so you know what to do. Any problems, you can talk about it on the day."

However, during the inspection, we noted inconsistency and gaps in daily monitoring charts. For example, in one person's care plan, there were observation charts for temperature, pulse and respiration (TPR), blood, respiration, O2 saturation and pulse. There were records of these on numerous dates such as 3/12/16, 20/01/16, 1/2/16, 9/3/16, 17/3/16, 23/3/16, 27/3/16, 11/4/16, 30/4/16 and 9/5/16. However, there was no detail about how often these checks should be carried out. There was no consistency in terms of how often these were carried out or should be carried out. For example, daily, weekly or other interval. .

In another person's care plan, we noted observations chart completed for 23/01/16, 2/2/16, 6/2/16, 8/2/16, and 14/2/16 x 5 at different times, 16/3/16, 14/4/16, 21/4/16 and 15/5/16. Once again there was no consistency and no information as to how frequent these observations should be.

In one person's. diabetes care plan, the blood sugar monitoring chart completed showed monitoring on 2/4/16, 9/4/16, 23/4/16, 30/5/16, 7/5/16 and 13/5/16. However there was no information to indicate how often such monitoring was to be carried out and we could therefore not determine whether such checks were being carried out appropriately.

We also looked at the some of the daily monitoring charts in people's rooms and found there were unexplained gaps. One person's bowel chart was completed on the 13/3/2016, 20/3/16 and 4/5/16. On the entry for the 4/5/16, it stated, "greenish colour and vomited". There was no further information to show whether any action had been taken to follow this up reported to the nurse or GP.

One relative we spoke to told us, "Staff sometimes do not look at the notes. On one occasion, the agency nurse told us [person] had to take three sachets but they have always taken one. It was only rectified because I pointed it out. Otherwise they may have given [person] three which would have made them ill."

We noted daily records were not always countersigned by the nurse. This would indicate that the care given by care staff was not always being monitored which could risk people receiving care and support which was inappropriate and unsafe. The registered manager told us staff were aware and have been told to ensure records were completed accurately. He told us he will ensure action will be taken to improve record keeping in the home.

The above evidence demonstrates that the daily monitoring needs of people using the service was not being carried out effectively. Accurate and contemporaneous records were not being recorded or effectively monitored in relation to people's care and support they needed and had received. This placed people at risk of receiving inconsistent and inappropriate care.

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

People's needs were regularly assessed, recorded and reviewed by staff. People signed their care plans where they were able to and records showed there was some involvement from family members. However, there had been no formal review meetings with people using the service and their relatives in which people's care was discussed and reviewed. This would ensure people's needs were being met effectively especially in

areas in which a person may not have the capacity to make certain decisions about their care. The registered manager told us there was regular contact with relatives and it was more on an informal basis but he said that he would ensure a formal review system was put in place. Minutes of a residents meeting also showed that the registered manager had discussed with relatives the need to participate in the review of people's care plans.

The home employed an activities coordinator. We spoke with the activities coordinator and she said that she visited those who were mostly in their rooms so that they could engage in conversation with her. The activities coordinator kept thorough records of what activities people participated in. She also told us that she read through care plans to learn more about residents and what they might like to do. For example, she had discovered that one person had enjoyed painting in the past and had encouraged the person to do some painting in the home. One relative told us that their family member enjoyed colouring and staff gave the person some colouring books.

The residents had a weekly plan of activities on top of individual activities. One person using the service told us, 'I have problem with my mobility and I spent most of the time in bed. I can't go the Mandir (temple) so the priest comes and visits me regularly and when I ask for him". The person also told us that they enjoyed music and watched Bollywood movies.

During the day, we observed people spent the majority of the time in the morning at the Temple. In the afternoon, most people choose to relax in the lounge areas, go their rooms or take a nap. We spoke with the registered manager about this and he told us that people mostly did what they liked in the afternoon and would then participate in evening prayers, dinner and then people would be getting ready to bed.

There were procedures for receiving, handling and responding to comments and complaints. There was a complaint policy in place and there was a system for recording complaints and we observed that complaints had been dealt with appropriately and promptly. When speaking with people they told us who they could speak with if they had any concerns. They told us, "I would talk to the carers", "I would talk to the [registered manager]" and "I would talk to [registered manager]" "if things weren't right and he would rectify things" and "I would tell my friends if things were wrong."

Records showed that 14 complaints/concerns had been received between April 2015 and April 2016. The complaints covered various areas of the service including medicines not received on time, lack of monitoring of food and fluid intake, cleanliness and hygiene of people's bathrooms, lack of staff, attitude of carers and the lack of choice available on the menu. There was documentation in place which showed the registered manager had responded promptly to resolve the issues raised and if needed disciplinary action was also taken against staff.

Requires Improvement

Is the service well-led?

Our findings

There was a management structure in place with a team of care staff, nurses, kitchen and domestic staff, admin manager, registered manager and the provider. A clinical services manager had also been recently recruited. Staff had a positive attitude and were of the opinion that the service was well managed and the registered manager was supportive and approachable. They indicated to us that morale was good and they had received guidance regarding their roles and responsibilities. One care worker told us, "They are supportive. We can go to the manager. He does listen if we need anything" and another care worker said, "The manager definitely listens and takes action."

Records showed regular audits and checks had been carried out at the home covering various areas such as housekeeping, catering, infection control and care planning. There were action plans which listed any actions that needed to be taken as a result of the audit and by whom. However we found the audits were not always effective. For example, there were processes in place to monitor how well medicines were managed, via daily and monthly medicines audits, There was a "daily medication audit form" in use, however it was not being used every day. For example, on the nursing floor the daily medicines audit had not been carried out since 25 April 2016, and we noted issues with medicines records, medicines fridge temperature monitoring and the use of an expired medicine that should have been picked up by these audits.

The provider also carried out a more detailed monthly medicines audit. We looked at the completed audits for the last 3 months and saw that these were effective in identifying some issues with medicines. We noted that an action plan was not drawn up after each audit, and there was no date of completion for the audit findings, so we were not assured that issues picked up with medicines would be addressed promptly.

We also noted that the quality of record keeping was highlighted in some audits. However there was no evidence to confirm that effective action was being taken as we still found concerns with records keeping during this inspection. For example, records showed that there were 'Walk the floor' reports which were conducted by management staff to ensure the home was running efficiently. These reports covered areas such as staffing, checking call bells, monitoring charts and speaking to residents. On the 12/5/16, there was an entry which stated 'ensure daily entries are signed off', on the 16/5/16, there was an entry advising the checking of MAR sheets and on the 17/5/2015 there was an entry advising staff of accurate record keeping.

The providers own checks also noted that the quality of the records keeping was poor. For example, when management staff conducted unannounced night visits at the home. Records for two visits unannounced night visits dated the 29/1/16 and 25/9/15 showed there were concerns about record keeping. Comments included, 'Staff were using well being chart but still not sure of how to record. This has been explained.'

During this inspection, we found daily monitoring records were not being kept so we could not be sure that people's needs were being monitored appropriately. The records for the night visits conducted by management on the 29/1/16 also highlighted this issue but effective action was not taken to address this and daily monitoring records continued to be completed inaccurately and with unexplained gaps. For

example, records showed charts were checked for Room 15; however the only entries were for 20.45 and 12am. For one person, checks were recorded for 20.30 and 12.05 and the audit states, 'no indication as to frequency of checks. For room 6, the person was to be checked every two hours but the last entry was 22.10pm. For room 9, the audit stated no charts had been completed since 23.00pm. The action listed to address this issue was for staff to ensure all charts were completed in a timely manner. However, effective action had not been taken to resolve this as we found still found concerns with record keeping during this inspection.

We looked at three audits completed by the provider but found the audits were limited to looking at certain areas such as the number of pressure areas, weight loss, infections, accidents, hospital admissions, deaths, complaints and safeguarding referrals. The audits showed actions to be taken if needed however the actions listed were sometimes ineffective. For example in the January 2016 audit, the action recorded for pressure areas was 'Review pressure care and associated documentation for Karuna Manor to be reviewed by the end of March.' This was once again repeated in the February 2016 audit. Although the number of concerns with regards to pressure care was noted, there was no further information as to what the issues were specifically, how this could be addressed, what measures were needed to be put in place to address the issues and how this was going to be monitored.

Records showed that complaints were reviewed during monthly audits by the provider. However, we noted the information was limited to noting the number of complaints received and action included for example was to, 'ensure all complaints were reported and discussed with the registered manager'. The reason for complaints were noted as 'Care' but did not provide any further information explaining what this meant and what the concerns raised actually were.

Although there was evidence that the registered manager took action to respond to complaints and resolved matters. There was no evidence which showed that concerns and complaints were evaluated and used as an opportunity for learning or improvement for the service or specific action plans in place to show action taken to improve areas of the service based on the complaints received. The registered manager told us they always responded appropriately to complaints and ensured matters were resolved to people's satisfaction. He told us he would ensure this was reviewed more effectively.

Although there were some quality assurance processes in place to assess and monitor the quality of service being provided and action had been taken, we found some of these were ineffective. Checks were completed but there was no effective evaluation of the issues and effective measures put in place. During this inspection, we found further concerns with regards to the management of medicines, the quality of record keeping and people's needs not being monitored effectively on a daily basis. This demonstrated the current systems in place were not robust enough to assess, monitor and improve the quality and safety of the services being provided to people.

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

The home had a range of policies and procedures to ensure that staff were provided with appropriate guidance to meet the needs of people. These addressed topics such as infection control, safeguarding and health and safety. Staff were aware of these policies and procedures and followed them. People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential.

The service had a system for ensuring effective communication amongst staff and this was confirmed by

staff we spoke with. Records showed and staff informed us that there were daily "group supervision" meetings where they could discuss any specific issues on a daily basis. We also saw evidence that there were staff meetings where staff received up to date information and had an opportunity to share good practice and any other concerns.

Meetings were held monthly for people living at the home as well as relatives where they could give their views on how the home was run. Minutes showed various areas were discussed such as catering, laundry, housekeeping, maintenance, consent, activities, care plans and involvement and complaints. People and residents were also asked whether they felt safe in the home and if they were treated with respect and dignity. Records showed people responded positively to these questions. Any actions that needed to be taken were noted to follow up.

The home had carried out an annual resident's satisfaction survey in 2016 and the results from the survey were positive. When asked what the best thing about home was, some of the comments provided were 'The freedom', 'the temple and 'support of all the management and the staff', communication', 'cleanliness' and 'well looked after.' The comments also included a positive comment referring to the caring nature of staff and stated, 'The staff still smiling even when some residents are not respectful."

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 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 Current arrangements in place did not ensure the proper and safe management of medicines which places people at risk of receiving their medicines incorrectly. People were not adequately protected from the risks of unsafe medicines management. Regulation 12 (2) (g)

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