Woodhouse Care Homes Limited

Pranam Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 21 and 22 June 2018 and was unannounced.

Pranam Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Pranam Care Centre can accommodate up to 50 older people some of whom are living with dementia in one adapted building. At the time of our inspection 31 people were living at the service. The home is owned by the provider Woodhouse Care Homes Limited.

There was a manager in post who registered with the Care Quality Commission in April 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection of the service was on 5 and 7 September 2017 when we rated the service requires improvement. Following this inspection, we asked the provider to complete an action plan to show what they would do. They provided us with an action plan that stated they would address concerns by the 31 December 2017 to improve the key questions Safe, Responsive and Well- Led to at least good. At the inspection of 21 and 22 June 2018, we found the provider had addressed some of the concerns we found at our last inspection but we found other concerns that meant all the key questions were now requires improvement.

At this inspection we found there were some hazards in the service that had not been identified and addressed through checks and audits. These included a fire exit which was partially obstructed by stored items, and an unlocked electric equipment room that contained flammable stored items. The outside areas of the home were not well maintained. There were cigarette ends that had not been picked up and litter that had not been cleared and which could have attracted pests. This made the outside areas unsuitable for people's recreational use. The registered manager addressed these concerns when we pointed these to them.

We saw one person had a swollen and bruised hand. This had not been noted by the care staff. We brought this to the attention of the registered manager who arranged for the person to receive medical attention. Following our inspection, we requested this was reported as safeguarding adults to the local authority as it was an unexplained injury and the registered manager ensured it was reported as required.

People's records we reviewed indicated that some people not been referred to the appropriate health care professionals when there had been a consistent weight loss and when they needed chiropodist treatment.

Records indicated people were not being supported to change their continence pads on a frequent enough basis. Daily recordings were not completed contemporaneously and were completed sometimes in advance which meant we could not be sure of their accuracy.

Most people said staff were "nice" and "good." Whilst most care staff supported people in a friendly and kind manner their responses to people who were upset or restless were not always adequate as they did not take time to identify what was troubling the person so they could offer a meaningful solution.

One care staff undertook the duties of activities coordinator from 10am -12pm and 2pm-4pm each day and although there were some activities the sessions were short and people told us how they no longer went out and felt there were not enough activities to keep them occupied.

The interior of the home was kept clean. One area had a malodour and we brought this to the attention of the registered manager who agreed to address this.

The provider was employing staff in line with their assessed rota and using agency staff when they did not have sufficient permanent staff.

The provider met with people to assess their needs before they moved to the service. The assessments were used to create person centred care plans that stated people's preferences and support needs. Where a risk to the person was identified, a risk assessment was completed with measures for staff to take to minimise the risks.

Medicines were administered and stored in an appropriate manner.

The provider worked in line with the Mental Capacity Act 2005 and applied for authorisations under the Deprivation of Liberty Safeguards(DoLS) in an appropriate and timely manner. People's care plans gave guidance for staff about how they made decisions.

The provider encouraged people and their relatives to raise concerns. The registered manager responded to complaints and had an oversight of complaints and safeguarding concerns to recognise trends in the service. The registered manager demonstrated they learnt from mistakes made in the home sharing learning with care staff and taking actions to prevent a reoccurrence.

The director who was also the responsible individual had been in both roles for two months had a clear vision and ethos for the development of the service to meet the needs of the local community

We found five breaches of regulations in relation to, person-centred care, dignity and respect, safe care and treatment, safeguarding adults from abuse and improper treatment, and good governance.

Full information about CQC regulatory responses to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 always safe. A fire exit was partially blocked and the home's external areas were not maintained to a safe standard.

The provider assessed staffing needs in the home and used agency staff when permanent staff were not available.

Care staff were not always vigilant in checking people for injuries so these could be treated and action taken to prevent similar incidents from happening again.

The provider used an electronic record for medicines administration and staff had been trained in its use. The medicine's administration was checked and audited by the registered manager daily and was safely carried out.

Is the service effective?

Requires Improvement

The service was not always effective. People were not always supported to see a healthcare professional when they had consistently lost weight and did not always receive chiropodist treatment in a timely manner.

People were supported to eat healthily and to drink enough to remain hydrated. However, the records of fluids people had consumed were not contemporaneous and therefore might not have been accurate.

The registered manager undertook assessments of people's needs prior to offering them a placement to identify their support needs.

The provider was working in line with the Mental Capacity Act 2005 (MCA) and had applied for Deprivation of Liberty Safeguards (DoLS) authorisations appropriately. Staff asked people's permission before providing care.

Is the service caring?

Requires Improvement

The service was not always caring. Staff did not interact appropriately and converse with people and instead they

concentrated on support tasks instead of the person.

Staff did not act with consideration and did not appropriately support people when they were distressed or restless.

Care staff spoke to people in their language of choice and care plans were explicit about how people communicated their preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive. There were limited activities for people to join in to keep them active and stimulated. People were not being supported to go outside and planned events did not always take place.

People's care plans were person centred and some reviewed contained people's end of life wishes.

The provider supported people to make complaints and had an oversight of complaints to identify trends so that they could take action to prevent reoccurrence.

Is the service well-led?

Inadequate

The service was not well led. The provider did not have effective systems of governance because their checks and audits had not identified the concerns we found at this inspection.

The registered manager met with people and their relatives so they could express their views and receive information about the service.

The registered manager welcomed visits from commissioning bodies and acted on their feedback to make positive changes to the service.

Pranam Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 21 and 22 June 2018 and was unannounced.

The inspection team consisted of two inspectors 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.

Prior to the inspection we reviewed information we held about the service, including notifications. A notification is information about important events that the provider is required to send us by law. We also looked at the action plan the provider had sent us and previous inspection reports. We read reports of visits undertaken by Healthwatch Ealing, a representative from one local authority and the London Fire Service.

We reviewed four people's care records. This included their care plans, risk assessments and daily monitoring records. We observed medicines administration and looked at nine people's medicines administration records. We spoke with five people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed staff interaction throughout the day including support given to people to eat both in the dining areas and in one person's bedroom. We inspected the environment and equipment being used by the provider.

We looked at three staff's personnel records, including their recruitment and training documentation. We spoke with five care staff, the chef, the registered manager, the area manager and director.

Following our inspection, we spoke with a representative of one commissioning authority.

Requires Improvement

Is the service safe?

Our findings

At the inspection of September 2017 we found that the kitchenette in the dining room was not well maintained. During this inspection of 21 and 22 June 2018 we found this area was now maintained appropriately. However, during this inspection we found that people were not always protected against the risks that can arise if the premises are not adequately maintained.

Two outside areas were unsafe for people to use. In a court yard area used by people who smoked there were a substantial amount of discarded cigarette ends and the table and chair seat covers were dirty and not fit for use. The waste paper bin was overflowing and the contents included orange peel and a fast food drink carton. There had been pest control concerns in April 2018 and this litter could have encouraged pests. In the garden area there was a low raised edging to the grass that was a significant tripping hazard. This had been identified in a Healthwatch visit report in November 2017 as a concern and had not been addressed by the provider. The was no risk assessment in place to that identified measures to mitigate this risk.

There were potential fire safety hazards. We found that a path just outside a fire exit from the home to the garden was blocked by a stack of metal scaffolding, over grown shrubs, an old tumble dryer and a table and chairs. In the event of a fire people might not be able to use this exit to get to safety. In the courtyard area where people smoked and were dropping cigarette butts, we found an electrical cupboard unlocked. There was an electric hazard sign on the door and an instruction to keep locked when not in use but this cupboard had not been kept secured. The electrical cupboard was also used for storage and contained used paint pots and cardboard that were stored beside the electrical panelling. This was a potential fire hazard. Therefore, the provider had failed to ensure that risks that people and others faced at the service were identified, assessed and mitigated.

The above concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The director arranged for the fire exit path and outside areas to be cleared immediately and told us how they would act to ensure the garden was made safe for people to use.

During our inspection we observed one person had a swollen and bruised hand. We were concerned, as although, this person had been supported by care staff during the morning the signs of this injury had not been noted by the care staff on duty. Therefore, the person was at risk of improper treatment and further harm. In addition, the staff had failed to follow the provider's procedures for reporting and acting on suspected abuse. We brought this injury to the attention of the registered manager who arranged for the appropriate medical treatment to be undertaken and took steps to find out how this injury had occurred. Following our inspection, we requested this injury to be raised as a safeguarding adults concern to the local authority as the cause of this injury was unknown.

The above concerns were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our findings about the safety of the premises, people told us they felt safe living at the home. Their comments included, "Yes, I am safe," "Of course I feel safe" and "Yes I feel safe here." The staff told us they had received training around safeguarding people from abuse. They could tell us what they would do if they saw signs of abuse and described how they would report any concern.

The provider sourced agency staff when there were staff absences to ensure there was the required number of staff on duty to meet people's needs. The registered manager assessed the staffing needs of people and for example if a person was distressed and required extra support they would ensure an extra staff member was on duty to meet that person's support needs.

Prospective care staff completed application forms and attended interviews to assess their aptitude, experience and skills for a caring role. The provider had requested references from previous employers. They undertook checks on staff criminal records and ensured they provided documents to confirm their identity and checked their eligibility to work in the United Kingdom.

The risks to people's safety and wellbeing had been assessed and planned for. Individual risk assessments included risks relating to mental and physical health, skin integrity, assisted moving, falls, use of equipment and nutrition. They had been reviewed and updated each month. The assessments included information about how people should be supported to minimise the risks.

We saw that risk assessments had been updated following changes in people's needs. For example, when one person had returned from a hospital admission their needs had changed. Their risk assessments reflected this and the information had been updated in the care plans. In addition, there was guidance from other healthcare professionals to accompany the provider's records. One person's care file we looked at identified that they were at high risk of choking. The risk assessment relating to this included guidance on how the person should be supported when eating, how they should be positioned and clear information about the texture of their food.

People's comments about the interior of the home was positive. Their comments included, "They keep the place clean and tidy" and "Yes, it is clean here." The provider employed two cleaning staff, one worked in the morning and the other in the afternoon. The interior premises were clean and well maintained. However, we noted on one corridor there was a malodour. One person who lived in a room adjacent to the corridor told us there was a, "Very bad smell outside." The cleaner had cleaned the area and there was there was a high use of air freshener. However, at times throughout the day the malodour persisted. We brought this to the manager's attention who agreed to address the matter which may require deep cleaning to address an underlying problem.

Staff had received infection control training, we saw appropriate use and disposal of protective equipment. The registered manager described that they tested staff competency by observing hand washing techniques and checked to ensure care staff used gloves and aprons appropriately.

People told us, "I am given medication on time," and "Yes, I get my medication on time but no one really explains to you what it is for." We observed medicines administration and checked medicines administration records for nine people. We identified no errors in the sample we looked at. The senior care worker administering medicines was well informed about the medicines in use and did, on most occasions, explain to people what their medicines were for. We found that for medicines that were given as and when needed there was guidance for staff on when to administer these.

At the inspection of September 2017, we found there was guidance for care staff as to the side effects of

people's medicines. This was not present at this inspection. The senior care worker told us they could look at the leaflets from the medicines packaging to be aware of side effects or The British National Formulary, which contains information about all medicines, that was available in the office. We brought this to the quality assurance manager's attention so that information in people's individual medicine administration records might be more readily available for care staff. They explained this information had been removed when they introduced the new administration system and they would replace it for easy staff reference.

The provider used an electronic scanning system for recording medicines administration. The senior care staff had been trained to use this. The system instructed care staff clearly when medicines were due to be given and prevented errors from occurring by flagging if the medicines were being given at an incorrect time or to the wrong person. The records produced by the system clearly showed when an error had been made and the registered manager demonstrated they audited the records daily and addressed any concern found. There had been an external auditing of the medicines administration by the local Clinical Commissioning Group (CCG) Pharmacy Technician who had visited the home in May 2018. Their report stated, "Since our last visit, [September 2017], there has been a significant improvement to how medicines are managed within the home." We also found medicines were being administered to people appropriately.

The registered manager had an overview of safeguarding adult concerns, accidents and incidents. They told us that they shared learning with care staff and discussed concerns with the quality assurance manager and measures to take to prevent mistakes from reoccurring. They gave some examples of actions they had put in place resulting from lessons learnt through safeguarding adult concerns. These included that staff now could carry a 'walkie talkie," a hand-held, portable, two-way radio transceiver, to ask for other care staff assistance rather than leaving the upper floors unstaffed. Due to concerns raised that the entrance doorbell was not being answered in a timely manner they had made the doorbell very loud so it could be heard across the ground floor. In addition, the director told us they had planned to move the registered manager's office to the main entrance area to ensure they had a central overview of people and staff in the home and were clearly visible to visitors.

Requires Improvement

Is the service effective?

Our findings

During our review of people's records, we found that whilst some people had been supported to access health care other people had not always been supported to access the dietitian and chiropodist in a timely manner.

We noted that three out of the four care plans we reviewed showed that people had lost weight whilst living at the home. Records indicated that appropriate action had not been taken by care staff in respect of two people. One person's monthly weight records indicated they had lost about 7% of their body weight since they moved into the service in November 2017 until April 2018. There was no recent weight that had been recorded at the time of the inspection. We found that a dietitian's referral had not been requested despite the steady weight lost. We brought this to the attention of the registered manager who spoke with staff and found that the person had been weighed in May 2018 but this had not been written into the records. They had lost a further 3kg in weight May 2018 which would indicate a total weight loss of in excess of 10% of their body weight. There had not been any action when the weight losses were identified. A form providing information about how to calculate the Body Mass Index (BMI), which is used to determine if a person is of a healthy weight had been photocopied many times and was no longer legible. Therefore, staff did not have clear information about how to calculate the BMI, as a clearer indicator of a person's nutritional status.

The second person had lost more than 20% of their body weight from June 2016 to April 2018, but the person had refused to be weighed on many occasions. The large weight loss had not been picked up on the occasions when the person was weighed and their refusal to be weighed had not been incorporated into their care plan. A BMI score was not calculated so there was a clearer indication of weight loss in relation to the person's nutritional status and no advice had been sought from healthcare professionals about other means to monitor the person's nutritional status. This meant people were not being adequately protected against the risks of malnutrition and when risks were identified, staff did not recognise the risks and did not make the necessary referrals to relevant healthcare professionals to make sure people were assessed and treated as necessary.

One person showed us that they had very long toe nails and told us they wanted their toe nails cut. We checked their records and found that they had last had their toe nails cut by the chiropodist on 17 January 2018. Their care plan stated that "Home activity co-ordinator manages [Person's name] hand nails but home to arrange a chiropodist visit from time to time, according to the needs of the resident." The care plan did not contain specific guidance for this person and therefore the care staff had failed to make regular timely appointments for the chiropodist to visit and to avoid foot discomfort for the person.

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

During the inspection we discussed these incidents with the registered manager who arranged for these people to have appointments with the relevant healthcare professionals.

Staff received training to support them to undertake their role. Staff who worked at the service had induction workbooks that recorded shadowing, policies and procedures and initial training. Training was mostly completed online but on some occasions, had been face to face. Staff had received training that included safeguarding adults, moving and handling, infection control, equality and diversity, first aid and dementia care.

The staff told us they had regular opportunities to meet with the registered manager to discuss their work. They had group supervisions where they explained that they could speak with them about any concerns and that these were quickly addressed. The group supervisions were also used for training for instance best interest decisions and duty of care had been discussed in December 2017 and dignity in care in January 2018.

People were supported to drink adequate amounts and were offered a choice of drinks. Drinks were available throughout the day in people's rooms and communal areas. The staff regularly offered people drinks and prompted when people were not drinking. Jugs of squash and water were in all communal rooms and were regularly refreshed by the staff. People were also offered nutritional supplements, tea and coffee. The staff recorded people's fluid intake on daily care notes.

People's comments about the meals served were mostly positive. They told us, "Food is good," "Food is fine but we could be given more fruit," and "The food is alright." There was a varied rotating menu of both traditional Asian and English meals. People could make choices about the food they ate. We checked the food order to ensure there was fruit available to people and saw that fresh fruit was ordered weekly.

During our observations in the ground floor dining room on the first day of the inspection, we saw that each person was given a meal they had previously selected from the menu. The staff explained what each item of food was and explained the other choices available to ask if people would prefer another choice. When one person said they wanted an alternative meal, this was provided. The food was nicely presented and most people in the dining room ate most or all their meals. People were offered a choice of desserts from a selection shown to them. People were also offered second helpings of their main meal.

One person was supported by care staff to eat a pureed meal in their bedroom. They were supported to eat in an appropriate upright position and the care worker sat with them and encouraged them to eat. Their care plan stated they were at risk from malnutrition as they had lost weight and there had been health professional input. A senior staff told us the person was a "pure vegetarian." We observed that they were offered a pureed meal of potato, carrot and cauliflower and rice pudding for desert. There was guidance for the chef regarding how to fortify their meal. However, whilst daily recordings stated what was eaten they did not contain detailed information about the fortification added to the meals. Therefore, it would be difficult for health professionals to monitor what was being provided if they had advised that individuals needed to have fortified meals. The chef told us how they fortified meals for people who required fortification with clarified butter and full fat yogurts. We saw that these foods were available in the kitchen.

People's healthcare needs had been assessed and recorded in their care plans prior to them living at the home. Where people had a specific healthcare condition, there was guidance for the staff about this condition and any specific needs relating to this. The information was clearly laid out. With the exception of the examples above, there was evidence of consultation with other healthcare professionals. This included guidance from them and information following appointments. In the majority of cases, the provider had responded appropriately to changes in people's healthcare needs, for example making referrals for additional healthcare support and updating care plans to reflect these changes.

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. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The staff told us they had received training regarding the MCA. They could explain how they would offer people choices and gain their consent before providing care. We witnessed this and people's choices were generally respected. Care plans included evidence of mental capacity assessments. These included decisions specific information and recorded where people had the capacity to make certain decisions. There was evidence that the provider had consulted with people's families and other representatives to make decisions in their best interests when they lacked the mental capacity to do so themselves.

The provider had made applications for DoLS authorisations for people who did not have the mental capacity to make decisions about their care or living at the service. These were evidenced in people's care records.

The home was built across three floors but only the ground and the first floors were used by people. There were adequate lounges and dining areas for people to use. The home had been adapted appropriately where required to ensure the premises were suitable for people living there, including for people who had a physical disability. There were bath and shower rooms that could be used for people with a mobility impairment and a lift that wheel chair users could utilise should they need to.

Requires Improvement

Is the service caring?

Our findings

People's comments about the care they received were mixed. Some people were positive about the staff and their comments included, "Yes, staff are nice," and "I think the staff do a really good job" and "The staff are good." One person pointed to a member of staff and said, "I like her." We saw this staff member had positive body language and put their arm around the person and asked them questions and demonstrated good person centred skills.

Some people were not positive about staff their comments included, "It's not nice here. There are some staff that raise their voices," another person said, "Staff sit around and they should be doing stuff."

When we observed staff interaction with people we found that there were times in the day when there was little or no communication between people and staff. The staff stood in the lounge rather than sitting and talking with people or engaging with them in other ways. When they were called away to do another task they were replaced by other staff members who did the same. They did not make attempts to involve people and were solely focussed on the tasks they were assigned to undertake.

There was very little or no communication between the staff and people using the service during the periods of our observations on the morning on 21 June 2018 from 9.45 -10.30am and again from 12.10 - 13.10pm during lunch. The staff spoke with people when offering them drinks or food only. For example, we observed one person was offered a glass of squash when they already had two full glasses beside them. There were very little other interactions, and these tended to be about a task or a subject the staff member was interested in. There was no evidence that the staff discussed things of interest to the person, such as about their family, hobbies or other known interests.

When people were restless or upset, care staff did not have the communication skills to reassure and work with people. For example, when one person was distressed a care worker did try and reassure the person. However, they did not ask what was wrong, but instead rubbed the person's arm and repeated, "It is ok, it is ok." They stood over the person and did not try to get on their eye level. The person looked frightened, but the staff member, whilst intending to help, demonstrated a lack of empathy and understanding.

We observed another person got out of their chair twice but they were encouraged to sit back down by care staff both times. We saw that the floor was wet as the person had become incontinent of urine. However, when they had got up they had not been asked what they wanted, whether they wanted to use the toilet or encouraged to walk for a while when they clearly wanted to move about. Therefore, the staff did not treat people with respect and did not support their autonomy and independence.

People were not always supported to appear well kempt. We noted for example, that one person's shoes were very dirty and required cleaning but care staff had not supported this to be undertaken. Some people were supported to protect their clothes from spillages but we noted an instance when one person's clothes protector was left on when they were not participating in any eating or drinking activity. It was also not clear if using the clothes protector was according to a person's needs or because it was a routine thing to do for

this person. The clothes protector for the aforementioned person was removed and put on again when they were having a drink but we observed they did not spill any of their drink and thought that perhaps this was not always necessary for them to use the clothes protector.

The above concerns were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they liked working with people, their comments included, "The best thing about being here is I enjoy it so much, I love helping people in any way I can,'' and ''I really like working here and I treat the service users like they are my auntie or uncle.''

Care plans stated how people communicated and the languages they spoke and understood. It was a strength of the service that staff spoke many of the Asian languages and could converse with people in the language of their choice. Care plans stressed that staff should respect the person's choices and preferences and gave guidance that stated for example, "Staff to respect [Person] and explain what is happening and obtain consent before offering personal care." Communication information was very clear in care plans reviewed and gave good information to staff about how to engage with the person. For instance, "[Person] needs support to effectively communicate, enjoys making conversations with someone, give enough time, go with the flow …speak slowly and clearly in a quiet manner."

Care plans stated when people liked time to themselves. For example, "[Person] is a private person. This needs to be respected." Care staff were able to tell us how they maintained people's privacy and dignity by closing bedroom doors before offering personal care and knocking on people's bedroom doors and waiting to be invited in before entering.

Requires Improvement

Is the service responsive?

Our findings

The records of care provided indicated that people were not receiving appropriate care in relation to their incontinence care needs. There were large gaps in recordings of people being supported to change their continence pads. For instance, two people's care records stated that they should have their continence pads changed every three to four hours. For one person their recordings indicated that on the 1 June 2018 they had their pad changed between 11am -12pm and then not again until 9pm -10pm This indicated a gap of between nine and eleven hours.

For the second person, on the 11 June 2018, their pad was changed between 7am-8am and then not again until 3pm -4pm, indicating a seven to nine hour gap. On the 13 June 2018, their pad was recorded as changed at 9pm- 10pm and then not until 9am-10am the following day, indicating a twelve to fourteen hour gap. There were other instances of long time gaps between changing people's incontinence aids. We had also witnessed during our inspection that a person might have become incontinent because they had not been supported to use the toilet when they tried to stand up. There was therefore a concern people were not being supported appropriately with their incontinence care needs and to change their incontinence aids in a timely manner so they remain comfortable and also to promote their dignity. We were not assured that this concern had been picked up by senior staff or the management team so they could address this.

People's social and leisure needs were not being met. Throughout the inspection, we observed most people were not engaged in any social or leisure activities. Activities that did take place, included a daily ten-minute exercise routine, were isolated and not sustained. We observed this in the ground floor lounge. Most people in the room participated and enjoyed the activity. They became animated and the staff member running the session complimented and encouraged them. However, the session lasted only ten minutes and no other activity was offered following this.

Later during the morning some people were given colouring pens, paper and building bricks. However, they did not engage with these and were not encouraged to by the staff. Twice we saw individual care staff pick up a pen and show this to one person. The person also held a pen and made one mark on the paper. The care staff did nothing else to encourage the activity or make this engaging and the person put their pen down and did not participate in any other activity.

One person invited us into their bedroom. They had a television that had been provided for them by a staff member, however there was no remote control so they could not watch it. Although the television had been in their room for several weeks this had not been addressed. Another person was on their own in their room. There was nothing in the room to engage them. We were told they would not sit with others but when the inspector asked once if they would like to come and sit with other people they immediately decided to do so and sat in a lounge area and looked relaxed. The activity coordinator described playing cards with people in their bedroom each week but the activities offered to people were limited.

At the inspection of September 2017, the activities co-ordinator sometimes took people out into the community. During this inspection they confirmed that visits out into the community had not taken place in

recent months. On the notice board there was a list of event dates happening at the service. One person told us that the planned visit to Southall park on the 14 June 2018 had not taken place. They said, "There is never anyone to take me out, I haven't been out for ages, No activities here." They continued to say, "There really are not any activities. We don't go out, well occasionally in the garden." We found that the garden area was not safe as it was not well maintained and was not attractive or inviting for people to sit in. Therefore, although some limited activities were taking place they were not person centred and did not engage people to participate in a meaningful manner.

One care staff undertook the duties of activities coordinator from 10am -12pm and 2pm-4pm each day. They told us their role was to provide social activities. They had a plan of daily activities. There was activities equipment available that included books, puzzles, radio, manikins, arts and crafts. There was a sensory room and the local church visited each week to pray with people who wished to do so. The activities coordinator made notes of activities undertaken with people however, our observations throughout the inspection showed that the time for activities and the quality of the activity was limited and did not meet the social and reactional needs of people.

Sometimes the information in people's care records about their preferences, likes and dislikes in regard to activities was limited. For example, in one person's care records the family had written that they liked traditional Indian music, Indian television channels and stories. However, the care plan created by the staff did not include this information and there was no evidence that this had been included in the activities they took part in.

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

People's care plans were mostly person centred and did contain information about people and how they would like their care provided. The registered manager had translated one care plan into the person's preferred language for them and planned to review and undertake this for other people so people could be more involved in their care plans. People's cultural needs were stated in the care plan for example their religion, background and language spoken were recorded. People were offered food which reflected their ethnic backgrounds.

We talked with the registered manager about how they supported people's lesbian, gay, bisexual, and transgender (LGBT+) diversity needs. The registered manager explained it was, 'Not a problem,' and that staff treated everyone the same and with respect for their choices. They provided same sex care staff if this was preferred by a person.

The provider's complaints procedure was displayed in the front entrance and there were copies in people's rooms. The complaints procedure had been translated into Gujarati, Hindi, Persian and Punjabi for people who spoke and read these languages. The registered manager kept a central record of complaints made and had an oversight to recognise trends in the service. There was evidence that concerns raised by people and relatives were addressed and resolved. The registered manager told us how they acknowledged complaints and investigated and addressed concerns appropriately.

The registered manager told us there was no one receiving end of life care at the service when we inspected. Some people care plans had end of life care plans. These informed staff of the person's religious and cultural requirements at the end of their life. The care plan told staff if there was an advanced decision made by the person stating if they wanted to be resuscitated in the event of their death and if there was a DO Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order in place.

Inadequate

Is the service well-led?

Our findings

At our inspection of September 2017, we found that the provider did not have effective arrangements to assess, monitor and improve the quality and safety of the services they provided to people using the service. During this inspection we found that the provider's systems to assess and monitor the quality of the service were still not effective. The provider had failed to identify, assess and mitigate risks to the health and wellbeing of people using the service. We found that the arrangements in place to check the safety of the premises and to maintain consistently safe fire exits from the service were not undertaken.

The provider was also not ensuring staff recognised and reported injuries appropriately to rule out possible abuse of people. They had not monitored people's conditions adequately to ensure people were receiving appropriate health care in a timely manner. They also did not ensure their staff had the necessary skills to engage with people when they were restless and for them to interact with people in a person centred manner.

In addition, the provider was not adequately monitoring the delivery of care. People's care needs, particularly those in relation to the management of their elimination care needs were not always being met. The provider had failed to identify these concerns or take appropriate action to make the necessary improvements. They had also not identified that people did not have stimulating and interesting activities to engage in so they led lives which were as fulfilling as possible.

The staff were not always maintaining accurate and contemporaneous records of the care provided. For example, they recorded the support they had given throughout the morning, including details of the person's wellbeing at specific times, personal care delivered and fluid intake, at one time just before the handover to other staff in the afternoon. Therefore, it was possible that these records were not an accurate reflection of care and treatment being provided. We looked at a sample of daily care records on the 21 and 22 June 2018 for people at 1.30pm in the afternoon and found that none of the care details, including fluid intake, had been recorded for the day. Therefore, whilst we observed people were supported to have a good level of hydration the staff may not be able to recall and record accurately all the drinks people had taken or personal care offered to people during the morning. This meant that the provider had not ensured that contemporaneous records were made to accurately record the care people received.

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

The director who was also the responsible individual had been in both roles for two months at Pranam Care Centre. There was a relatively new registered manager and a new deputy manager. They were being supported by the area manager who had a responsibility for quality control.

The director had created an action plan for improvements. As part of this this they were investing in initiatives such as the electronic medicines system to ensure the sustainability and improvement of the service provided. They described their ethos was to ''bring the care they provide into the 21st century with

the use of technology''. The provider aimed to provide care to a diverse and multicultural community. The registered manager had already translated the complaints procedure and a care plan into relevant languages spoken by people in the home. They stated their intention to expand this good practice to reflect that they could meet the needs of the local community.

The registered manager told us they felt well supported by both the director and the area manager They had recently recruited a new deputy manager to support with managerial duties and to offer additional support to the care staff.

In May 2018 there had been a London Fire Service visit that had identified some areas which required attention. The director had drawn up an action plan and was addressing the concerns identified and the fire risk assessment was in the process of being updated when we inspected. Checks such as the yearly gas safety check, electrical wiring testing, legionella and equipment checks had taken place. There were daily environmental checks that included infection control. The provider also carried out monthly audits that included health and safety.

People views about how the home was run were mostly positive. Their comments included, "It's not going to be like home but it's well run," and "It's a lovely place," however one person said, "They could do a lot of things better but they don't." New people were given a "Service users guide," that informed them of their rights including how to complain or raise a concern. The registered manager met with people and family members on a regular basis to listen to their views and provide service updates.

The staff told us they had regular opportunities to meet with the registered manager to discuss their work. They had daily handovers of information about each person living at the home and felt these were sufficient to undertake their duties and care for people safely. The staff were positive about the management team. Their comments included, ''The service has improved quite a lot, each new manager has bought something good and the current manager is very good,'' and ''The team work is the best thing, there is really good communication and we all get along.''

The management team described how they maintained their own learning, as such the registered manager was going to be attending the next local authority provider forum. The registered manager had ensured the service was registered with Skills for Care to get the support to help meet care staff training needs and to also be supported to better understand changes of legislation and the implications on running a care service. The director had attended a "Train the trainer falls," which is a training to be able to train staff to help manage and prevent falls occurring. There had been visits by two commissioning bodies prior to our inspection and the service had made some changes recommended by the visiting officers. We saw that the provider was willing to work in partnership with other agencies and to make improvements at the service.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure service users were treated with dignity and respect or support the autonomy and involvement of service users. Regulation10 (1), (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure that care and treatment was provided in a safe way for service users because they had not assessed the risks or done all that was reasonably practicable to mitigate any risks. They had also not ensured that the premises were always safely maintained. Regulation12(1), (2)(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not ensure service users were protected from abuse and improper treatment because they sometimes disregarded the needs of service users for care and treatment.

Regulation 13(1), (4)(d)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure that care and treatment of service users was appropriate, met their needs or reflected their preferences. Regulation 9(1)

The enforcement action we took:

We have issued a warning notice to the provider requiring them to be compliant with this regulation by 01 September 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not operate effective systems and processes to assess, monitor and improve the quality of the service, assess, monitor or mitigate risks to the health and safety of service users or maintain accurate, complete and cotemporaneous records of the care and treatment provided to service users. Regulation 17(1), (2)(a)(b)(c)

The enforcement action we took:

We have issued a warning notice to the provider to be compliant with the Regulation by 01 October 2018.