Meera Nursing Home Limited

Meera House Nursing Home

Inspection report

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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

The inspection took place on 25 and 26 February 2019. The inspection on 25 February was unannounced but we told the provider we would return the next day to complete the inspection. Meera House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission [CQC] regulates both the premises and the care provided, and both were looked at during this inspection.

Meera House Nursing Home is a care home with nursing operated by Meera House Nursing Home Limited. It is registered to provide accommodation with personal and nursing care for 59 older people, some of whom have dementia. This location is also registered to provide personal care for people living in their own homes. However, they did not have any people using this service at the time of this inspection. The care home provides care for people of Asian origin and most of the people living there are of the Hindu faith.

There were two registered managers in post at the time of our inspection. One of the registered managers was initially employed to manage the domiciliary care service. As they currently had no service users, this manager co-manages the care home with the second registered manager. 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.

We brought this inspection forward as we had received information of concern and feedback from local authority monitoring visits. These concerns related to the care of people and the management of the home. At our last inspection on 22 and 23 May 2018 we found a number of deficiencies and the service was rated "Requires Improvement". At this inspection we noted that although improvements had been made and some deficient areas rectified, there were still some areas where further improvements are needed. Therefore, the service continues to be rated as "Requires Improvement".

Risk assessments had been prepared for people. These contained guidance for minimising potential risks such as risks associated with falls, medical conditions such as diabetes and pressure sores. However, we noted that there were no risk assessments for people who used bedrails. This was later provided. One person who was at risk of choking did not have a comprehensive risk assessment. This was provided after the inspection. A person who had a history of depression and who was emotionally upset when we met them did not have a depression risk assessment. Comprehensive risk assessments are needed to ensure that care workers are informed of potential risks to people and how risks could be minimised to keep people safe.

The service followed safe recruitment practices and records contained the required documentation. Care workers told us they had received a comprehensive induction and training programme. Staff supervision and appraisals had been provided and these were recorded in the staff records. Meetings had been

organised for care workers. We were, however, not confident that the staffing levels were adequate to ensure that people's needs were attended to. This was because of certain deficiencies identified such as the slow response to call bells and those related to care documentation. The registered manager stated that a new deputy manager had been recruited and additional staff were in the process of being recruited.

The service worked with healthcare professionals and ensured that people's healthcare needs were met. The care needs of most people had been attended to. Care plans had been reviewed with people or their representatives. However, documented evidence indicated that some people' s care needs had not always been attended to, particularly those needing pressure area care.

Checks and audits of the service had been carried out by the registered managers. Audits had been carried out weekly and these were discussed in weekly management meetings. We however, noted that these audits were not sufficiently effective as they did not identify and promptly rectify the deficiencies noted by us. A satisfaction survey carried out recently indicated that people and their representatives were mostly satisfied with the care and behaviour of care workers.

We looked at the arrangements for safeguarding people. The service had a safeguarding policy and a whistle blowing policy to ensure that people were protected from harm and abuse. Care workers we spoke with had been provided with training on safeguarding people and knew what action to take if they were aware that people were being abused.

There were arrangements for the administration of medicines. Medicine administration record charts (MAR) and the controlled drugs register had been properly completed. Medicine audits had been carried out.

With one exception, the premises were kept clean. Concern had been expressed regarding rodent activity. We did not see evidence of this at the inspection. We saw evidence that the home had a contract for pest control and the last report by the pest control contractors indicated that there was no sign of rodent activity either in the home or outside the home.

There was a record of essential maintenance and inspections by specialist contractors. Fire safety arrangements were in place. These included weekly alarm checks, a fire risk assessment, drills and training. Personal emergency and evacuation plans (PEEP) were prepared for people to ensure their safety in an emergency. The hot water temperatures had been recorded prior to people being provided with a shower. This is needed to prevent scalding.

We checked and noted that window restrictors had been installed in most bedrooms we visited. One bedroom and a toilet did not have window restrictors. Restrictors were fitted to the bedroom window on the second day of inspection. The registered manager stated that restrictors were fitted to the toilet soon after the inspection. One bedroom had water stains on the ceiling. The registered manager agreed to arrange for checks of the roof to ensure that there were no leaks.

The nutritional needs of people were met. People had been assessed and arrangements were in place to meet their dietary and cultural preferences. All people living in the home were of Asian origin and only Asian vegetarian meals were provided. People informed us that they were satisfied with the provision of meals.

The home had an activities organiser and there was a varied activities programme to ensure that people received social, religious, cultural and therapeutic stimulation. People were mostly satisfied with the activities provided.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS ensures that an individual being deprived of their liberty is monitored and the reasons why they are being restricted are regularly reviewed to make sure it is still in the person's best interests. Mental capacity assessments had been carried out, but some details had not been provided. In addition, one DoLS authorisation had not been notified to the CQC. This was submitted soon after the inspection.

There were opportunities for people and their representatives to express their views and experiences regarding the care and management of the home. We however, noted that only one relatives' meeting had been held in the past twelve months. The registered manager stated that more would be held. This would enable people and their representatives more opportunity to discuss the care provided. Complaints made had been recorded and promptly responded to.

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

Risk assessments had not been prepared for all people who required them. One bedroom and a toilet did not have window restrictors. The call bell was not answered promptly.

There were safeguarding arrangements to ensure people were protected from abuse.

The premises had been renovated and arrangements were in place for infection control.

Is the service effective?

Good

The service were not effective.

Care workers had received the necessary training, support, supervision and appraisals needed to carry out their roles.

The service worked with healthcare professionals to ensure that people's healthcare needs were met. The nutritional needs and dietary preferences of people were attended to.

Mental capacity assessments had been carried out, but some details had not been provided. One DoLS authorisation which had not been notified to the CQC was submitted to us soon after the insoection.

Is the service caring?

Good

The service was caring.

People and their relatives told us that care workers treated people with respect and dignity. People's privacy was protected. Care workers communicated well with people and were able to form positive relationships with them.

There were arrangements for encouraging people to express their views. However, more meetings for people's representatives

were needed so that the service can obtain regular feedback from them.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

The care needs of most people had been attended to. Care plans had been reviewed with people or their representatives. However, documented evidence indicated that some people' s care needs had not always been attended to, particularly those needing pressure area care.

There was a varied activities programme and people's cultural and religious needs were met.

People and their relatives knew how to make a complaint if they needed to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Checks and audits of the service had been carried out. We however, noted that these were not sufficiently effective to ensure that deficiencies were identified and promptly responded to.

There were meetings where care workers were updated regarding the care of people and the management of the home.

A satisfaction survey had been carried out and the results indicated that people and their relatives were mostly satisfied with the care workers and activities provided.

Meera House Nursing Home

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 checked 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.

The inspection took place on 25 and 26 February 2019. The inspection on 25 February 2019 was unannounced whilst the inspection on 26 February 2019 was announced. The inspection team consisted of one inspector, an inspection manager, a specialist nurse advisor, a Gujarati interpreter 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.

Before we visited the home we checked the information that we held about the service and the service provider including notifications about significant incidents affecting the safety and wellbeing of people who used the service.

The provider had completed a Provider Information Return (PIR) in 2018. However, this had not been updated as this inspection was arranged at short notice. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR also provides data about the organisation and service.

A few 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.

There were 51 people living in the home. We spoke with 17 people who used the service, five relatives. We also spoke with the two registered managers, the chef, six care workers, three nurses, a healthcare professional and a director of the company. We received further feedback from three care professionals.

We looked at the kitchen, medicines room, communal areas, garden and people's bedrooms. We reviewed a range of records about people's care and how the home was managed. These included the care records for

eleven people, seven recruitment records, training records, staff supervision and appraisal records. We checked the audits, policies and procedures and maintenance records of the home.

Requires Improvement

Is the service safe?

Our findings

People and relatives informed us that people were safe in the home. One person said, "I feel perfectly safe – all the people around me are good". They give me medicine and come round and ask me how I am." A second person said, "It's safe here. There is a call system. Staff know the needs of patients when they ring the bell. Can talk to nurses in English and staff in Hindi and I can always explain what I need". A relative said, "If my relative is not well staff phone me. They check her vitals. A nurse is always available. She is happy here compared to home as she sees people. She is safe now."

The service had a safeguarding policy and a whistle blowing policy to ensure that people were protected from harm and abuse. Care workers were aware of these policies and they had been provided with training on safeguarding people. Care workers were able to describe the process for reporting concerns and were able to give examples of types of abuse that may occur. They told us that if they knew that abuse was taking place, they would report it to the registered managers. They informed us that they could also report it directly to the local authority safeguarding team and the CQC if needed.

We visited bedrooms and communal areas of the home. With one exception, all areas of the home were found to be clean. Concern had previously been expressed regarding rodent activity. We did not see evidence of this. The home had a contract for pest control and the last report by the pest control contractors indicated that there was no sign of rodent activity either in the home or outside the home.

We checked and noted that window restrictors had been engaged in most bedrooms we visited. We found that there were no window restrictors in one bedroom although there were bars across the window. A toilet with a sloping ceiling and a skylight window did not have a restrictor. A window restrictor was fixed on the second day of inspection to the window of the bedroom. We were informed that a restrictor was fitted to the toilet soon after the inspection. One bedroom had water stains on the ceiling. The registered manager agreed to check the roof to ensure that there were no leaks."

We activated the call bell in two bedrooms. One was not answered. Another was only answered after three minutes. The registered manager stated that he would instruct care workers to be more vigilant in answering the call bells. He explained care workers may not have answered as they may be aware that the people in the bedrooms concerned were not in.

We looked at staffing levels in the home and discussed them with care workers, people and their relatives. The people we spoke with said there were sufficient care workers. On the day of inspection there were a total of 51 people who used the service. The staffing levels during the day shifts normally consisted of the two registered managers together with teams of staff for each unit. Each of the two units had one nurse and six care workers in the morning. In the afternoon and evening shifts there was one nurse and four care workers. During the night shifts there were two nurses and four care workers for the whole home. In addition, the home had a team of household staff including three kitchen staff, two cleaners, a maintenance person and an activities organiser.

We examined the staff rota and discussed staffing levels with the managers, care workers, people and their representatives. They expressed no concerns regarding staffing levels. We also noted that during the inspection, care workers did not appear rushed and they stated that there were enough staff to attend to people. Our nurse specialist observed that staff could attend to the needs of people and she did not see people waiting for attention or left alone in rooms if they were at risk. We however, noted that until recently some staff had worked long hours. This may result in care workers becoming too tired and stressed. The registered manager stated that this had stopped recently and this was evidenced in the staff rota.

We noted some deficiencies which indicated that staffing levels may be inadequate. The call bells we activated in two bedrooms were not promptly answered. One was not answered while another was answered after three minutes. We further noted that some care documentation had not been fully completed. This included some fluid charts and repositioning charts for those at risk of pressure sores. In addition, the home used a clinical lead who visited only once per week.

Plans for improvement were in place but they were not yet completed. This is why we have rated the service as "Requires Improvement". To be rated "Good" the service needs a consistent track record of compliance with the regulations.

In view of the above, we are not confident that the existing staffing levels are adequate. The registered manager and a director informed us they had reviewed their staffing levels and recruited a new deputy manager. This was because they were aware that more clinical support was needed in the home. They also stated that additional administration would be recruited to assist in preparing electronic care documentation. They stated that they had advertised for more nurses. However, the response was poor."

Risk assessments had been prepared for people. These contained guidance for minimising potential risks such as risks associated with falls, medical conditions such as diabetes and pressure sores. We however, noted that there were no risk assessments for people who used bedrails. This is needed to ensure the safety of people. The bedrail risk assessment was provided later. One person who was at risk of choking did not have a comprehensive risk assessment. We found that their care plan only mentioned that they should be positioned at 40 degrees and to ensure they were awake before offering a drink. The registered manager explained that they were in the process of transferring all care documentation into electronic format. He provided us with evidence of the risk assessment after the inspection. A person who had a history of depression and who was emotionally upset when we met them did not have a depression risk assessment. This is needed to ensure they receive appropriate care. The registered manager stated that these would be prepared. Comprehensive risk assessments are needed to ensure that care workers are informed of potential risks to people and how risks could be minimised.

Failure to provide adequate risk assessments which included guidance to care workers for managing risks to people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

There were arrangements for the recording, storage, administration and disposal of medicines. The home had a medicines policy. We examined ten medicine administration record (MAR) charts. There were no unexplained gaps. This indicated that people had been given their prescribed medicines. The controlled drugs register had been properly completed and the amount of remaining drugs were found to be accurate. Audit arrangements were in place. The temperature of the fridge and room where medicines were stored had been checked daily to ensure they were within the required temperature range.

Personal emergency and evacuation plans (PEEP) were prepared for people to ensure their safety in an

emergency. There were arrangements for ensuring fire safety. The home had an updated fire risk assessment for providing guidance on managing potential risks. The emergency lighting had been checked by specialist contractors. The fire alarm was tested weekly to ensure it was in working condition. A minimum of four fire drills had been carried out in the past 12 months to ensure that staff and people knew the action to take in the event of a fire. Fire procedures were on display in the home. Care workers had received fire training. The registered managers informed us that the London Fire Service had visited the home in October 2017 and were satisfied with the fire safety arrangements. They had however, not provided a report of their findings to confirm this. Evidence that they had visited was recorded in the visitors' book.

The hot water temperature to the bedrooms and bathrooms had been checked monthly by the maintenance person to ensure that it did not exceed 43 degrees Celsius. Care workers checked the hot water temperatures prior to people being provided with a shower. This was needed to prevent scalding.

The service had a record of essential maintenance carried out. These included safety inspections of the passenger lift and gas boiler. The electrical installations inspection certificate indicated that the home's wiring was satisfactory.

The service had a recruitment procedure to ensure that care workers recruited were suitable and had the appropriate checks prior to being employed. We examined a sample of seven records of care workers. We noted that the records had the necessary documentation such as a Disclosure and Barring Service check (DBS), references, evidence of identity and permission to work in the United Kingdom. The current registration details of nursing staff were available to ensure they were fit to practice.

People informed us that their bedrooms had been kept clean. The home had an infection control policy together with guidance regarding infectious diseases. Gloves and aprons were available for use by care workers.

The service had a current certificate of insurance and employer's liability.

Good

Is the service effective?

Our findings

The last comprehensive inspection we carried out on 22 & 23 May 2018, found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing. The service failed to provide appropriate support, supervision and appraisals to enable staff to carry out their duties. During this inspection in February 2019, we found that the service had taken action to comply with the requirement. The service had arrangements for supporting care workers. Care workers said they worked well as a team and received the support they needed. The registered manager and nursing staff carried out supervision and annual appraisals of care workers. This enabled them to review their progress and development. Care workers we spoke with confirmed that these took place and we saw evidence of this in the staff records.

The home provided us with details of training that had been arranged for staff. We saw copies of their training certificates which set out areas of training. Topics included infection control, safeguarding adults, moving and handling, health and safety, equality and diversity, infection control, Mental Capacity Act and safeguarding people. New care workers had been provided with an induction programme. This was comprehensive and lasted five days during which they shadowed a more experienced care worker.

People and their relatives informed us that people had access to healthcare services and could see their GP if needed. People's healthcare needs were closely monitored by care workers and healthcare professionals who visited the home. Care records of people contained important information regarding their background, medical conditions and guidance on assisting people who may require special attention because of their medical conditions and mental state. Appointments with healthcare professionals had been recorded. We saw evidence of recent appointments with healthcare professionals such as people's GP, medical consultant, physiotherapist and chiropodist.

Arrangements were in place to ensure that the nutritional needs of people were met. People's nutritional needs had been assessed. Our specialist nurse advisor noted that there was guidance within people's care plans about the support needed by people at meal times. We however, noted that in the care records of a person it stated, "needs to be fed". The language used is inappropriate for an adult as adults should be assisted to eat. The registered manager stated that they would review the wording used.

Care workers and kitchen staff were aware of the special dietary needs of people such as diabetic diets and soft pureed diets. All people living in the home were of Asian origin and only Asian vegetarian meals were provided. We observed people having their lunch and spoke with them. The meals were presented attractively. People told us they were satisfied with their meals.

We checked whether the service was working within the principles of The Mental Capacity Act 2005 (MCA). The 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. Mental capacity assessments had been carried out for people. Where people lacked capacity, information regarding

next of kin or people to be consulted were documented in the care records. We however, noted that these lacked detail such as what decisions were made in people's best interest such as the use of bedrails and about the medicines to be administered. We further noted that in one instance the registered manager stated that a relative had lasting power of attorney but this was not mentioned in the mental capacity assessment and no evidence of this was obtained. The registered manager agreed to obtain the evidence and review care documentation related to the MCA. Staff explained how they applied the MCA. They were aware of the need to record best interest decisions where needed. They stated that they had received MCA training. After the inspection the registered manager sent us examples of MCA assessments made related to nutrition, personal care and bedrails.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Applications for DoLS had been submitted to local authorities and one authorisation had been given for a person four months previous to this inspection. The CQC had not been notified of this authorisation. This was sent soon after the inspection.

Good

Is the service caring?

Our findings

People and relatives informed us that care workers were pleasant and caring towards people. One person said, "Staff are approachable and helpful". A second person said, "I'm happy living here. Its good". A third person said, "Its wonderful here. People here are lovely, staff and residents. Food is very good. They treat me with respect. All my needs are attended to. I have not been here very long, and I have made friends". A care professional informed us that care workers knew people well and were very good at caring for them.

We spent time observing the interaction between care workers and people. We noted that care workers were warm and caring towards people. The atmosphere in the home was cheerful. Communication with residents was good and people and care workers were seen laughing together. Many of the care workers spoke the same language as people and this was working well. We saw a care worker who did not speak the same language as a person using sign language and they were clearly communicating well. Care workers spoke respectfully to and about people. We saw one person being assisted to eat and this was done with care. The care worker talked to the person concerned and showed what was available and with patience.

The service had a policy on promoting equality and valuing diversity (E & D) and respecting people's individual beliefs, culture, sexuality and background. Care workers were aware that all people should be treated with respect and dignity. This was confirmed by people and relatives we spoke with.

The registered managers stated that they celebrated various cultural events. These included Christmas, Easter, Diwali and Navratri (Hindu Festival prior to Diwali). The home had a room which was organised as a Hindu shrine for people. Incense was burnt in this room to facilitate religious observances of people.

Care plans included information regarding people's individual needs including any special preferences and interests. We noted that arrangements had been made to meet the religious needs of people. People joined in "Puja" (religious prayers) and singing "Bhajans" (religious songs). This was organised every morning.

Meetings had been held where people could express their views and be informed of any changes affecting the running of the home such as accessing care records, activities and concerns people may have. We however, noted that only one meeting for relatives had been held in the past twelve months. The registered manager stated that more would be held. This would enable people and their representatives more opportunity to discuss the care provided.

People were supported to maintain relationships with family and friends. They told us that they had been visited by their relatives. We noted that there were several relatives present in the home during this inspection. Care workers were pleasant and respectful towards them.

The bedrooms we visited were comfortable. They had been personalised with people's own ornaments and memorabilia. Pictures of people were displayed on their bedroom doors.

We discussed the steps taken by the service to comply with the Accessible Information Standard. All

organisations that provide NHS or adult social care must follow this standard by law. This standard tells organisations how they should make sure that people who used the service who have a disability, impairment or sensory loss can understand the information they are given. We noted that notices around the home were in Gujarati and English. Pictorials to assist people with communication difficulties were in both English and Gujarati for people who have difficulty in speaking. In addition, we noted that the lift had verbal instructions in Gujarati and we saw care workers communicated in Gujarati with people.

Requires Improvement

Is the service responsive?

Our findings

We discussed the care of people with the registered manager and nurses on duty. We checked people's care documentation to ensure that these provided essential information about people and the care to be provided. They contained assessments of people's needs and personal information such as their social history, interests, culture, religion and what people who were important to them. Following these assessments, care plans had been prepared. They covered areas such as communication, personal hygiene, sleeping, elimination/continence, medicines, mobility, moving and handling, nutrition and hydration, falls, tissue viability, diabetes and hopes and concerns for the future. Daily notes had been written regarding people's progress. Some of the daily notes and care plans were not easy to read as the handwriting was not always legible. The registered manager informed us that they were aware of this and they were also in the process of transferring people's records into a new electronic format on the computer.

We also looked at specific areas of care such as the care of people with diabetes. Diabetes care plans were in place and there was specific guidance for care workers on the care of people concerned. Reviews had been carried out by healthcare professionals such as people's GP and the diabetic nurse. There was information on the dietary needs of people with diabetes. People's blood glucose levels had been checked daily before medicines were given. We however, noted that in one care record, the dose of insulin on the MAR chart was different to what was stated on the care plan. The registered manager stated that they would check this so that it can be rectified.

We also looked at the care of people with pressure ulcers was discussed it with nurses on duty. We found that Waterlow pressure sore assessments had been carried out. Following this pressure area care plans, pressure relieving mattresses and repositioning charts were provided for people when needed. There were air mattress monitoring charts in the bedrooms of people who had pressure relieving mattresses. They were checked to ensure they were operating correctly. However, the pressure area care plans of people at risk of pressure sores did not mention checking air flow mattress settings. There was some confusion with information about settings. In one care record it stated that the mattress should be on a "soft setting" but the registered manager told our specialist nurse advisor that the mattress was automatically set at the correct setting. This was brought to the attention of the registered manager who agreed to review the guidance. After the inspection, the registered manager explained that all their pressure relieving mattresses were on auto setting and adjusted in response to people's weight, movement and position. There was an additional facility within the pump to adjust the comfort level for people. This can be set at soft, medium or seated.

We also noted that some people's repositioning charts were not fully completed. For example, one person's chart indicated that they needed to be repositioned every two hours but there were some large gaps in the record chart. For another person on the night of 22 to 23 February nothing was recorded between 19.20 hours and 08.30 hours the next morning. On the day of the inspection there was no evidence of repositioning between 06.30 hours and 13.00 hours. According to the care plan the person who used the service should have been moved 4 hourly. The registered manager stated that some of the timing was entered using the12 hour format and others were in 24 hour format and this which may have been misinterpreted by the

inspectors.

Due to inadequate recording we cannot be confident that people were receiving appropriate care which met their needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care.

Formal reviews of care had been arranged with people and their relatives. Following this people or their relatives had signed the updated care plans. We however, found that some care plans needed to be updated. For example, the care plan of a person stated that they used a walking stick and needed supervision to go out but on checking we found that the person concerned no longer used a stick and they were able to go out alone.

Most people and relatives we spoke with informed us that they were mostly satisfied with the care provided. People made the following comments, "Staff give me a shower and help me change clothes. They come at 8.30 to get me up. If they are late I ring the bell and they come in five minutes. Staff speak to me lovingly", "I'm happy living here. Its good", "I'm always in bed. Happy living here. Staff look after me well, I can't go to toilet myself and they clean me up and they do my hair and they do everything for me", "I have no complaints against anyone. Everything is good. Enough staff but they are very busy everywhere", "I like living here. Accommodation is fine and food good. People who work here look after me well. Even at night time".

The home employed an activities co-ordinator and we noted that there were various religious and therapeutic activities and celebrations organised for people. During the days of inspection, the activity co-ordinator had organised a quiz, some singing and a good percentage of people joined in or tapped their feet or hands. There were chair exercises which again got a good response from people. One person was in another room and a staff member came in and asked if the person would like to join in the exercises, she said "no" but the staff member asked if they would like to watch the session instead and this person agreed. This appeared to be an appropriate and sensitive way to encourage the person to join in and avoid social isolation. The sessions were well organised and presented in more than one language and appeared to be understood by people. In the afternoon there were two entertainers singing in the lounge and playing on a keyboard.

Hindu and cultural events had been organised. They included Swami Narayan group (religious recitals), Utran (festival of Kite), Shrawan month (prayer for Lord Shiva), Diwali and Christmas. Other activities included Live Music Bollywood songs, quiz, card games and colouring books. Some people informed us that there were enough activities for them while others wanted more activities. They made the following comments, "I pass the time doing knitting. Sometimes I cut vegetables. I can't sit for too long so I do not do the activities", "There are enough activities. I like the music best". "During the day, lots of activities. I like singing and people here are easy to get on with", "Family comes and sometimes take me out. I don't go in the garden - no place to sit", "I like gardening. I do exercises and yoga and listen to the singing" and "There are no outings". Comments made by relatives included the following, "They could do with more activities. There are Indian hymns and exercises every day".

The home had a complaints policy which was displayed at the entrance of the home. We examined the record of complaints and noted that complaints had been promptly dealt with. A complaints audit was carried out weekly. People and relatives we spoke with knew that they could complain to the registered manager if they had concerns. One of the registered managers was allocated responsibility for responding to complaints.

The service provided end of life care. Information regarding whether a person is to be resuscitated had been

discussed with people and their representatives and information recorded in the care records. We however, noted that in one instance the records stated "fulfil her wishes" but did not specify what they were. The registered manager stated that they would review information related to end of life care so that detailed information is obtain where possible. He however, stated that certain people of Asian origin found it distressing to talk about end of life care.

Requires Improvement

Is the service well-led?

Our findings

The last comprehensive inspection we carried out on 22 & 23 May 2018 found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance. The service did not have effective quality assurance systems for assessing, monitoring and promptly improving the quality of the quality of care provided for people. During this inspection in February 2019, we found that the service had taken action to comply with the requirement. Checks and audits of the service had been carried out by the registered managers and directors of the company. We saw evidence of weekly audits carried out by the registered managers into areas such as the maintenance and cleanliness of the home, complaints received, medicines administered and accidents reported. In addition, spot checks had been conducted by an external professional. The registered manager informed us that where deficiencies were noted they had taken action and this included following up on complaints made and deficiencies identified in local authority monitoring reports.

We however, noted that checks and audits were not sufficiently comprehensive. They did not identify and promptly rectify deficiencies we noted. These related to the lack of risk assessments for those needing bedrails and a person with a history of depression. We found that one bedrooms and a toilet did not have window restrictors. In addition, when we activated the call bells in two bedrooms, they were not promptly responded to. We also noted that some pressure area re-positioning charts and fluid charts had not been fully completed. We also received information from two local authorities which indicated that there were a number of deficiencies related to the care of people and the running of the service. These included deficiencies in care documentation. We therefore conclude that the service did not have effective quality assurance systems for assessing, monitoring and promptly improving the quality of the quality of care provided for people.

The registered managers and a director stated that they had made improvements and these included fitting the window restrictors but they were willing to further rectify deficiencies noted. They informed us that they had recruited a new deputy manager and contracted an external professional to carry out regular quality monitoring audits. They were also in the process of involved in falls prevention assessments with other healthcare professionals, starting a new electronic care planning system, and planning to develop end of life care with a nurse from the local hospice. The registered manager also informed us that they had been selective and only admitted people into the home whose needs they can met. After the inspection we also received information from a local authority that the service had made improvements in addressing some of the deficiencies they had identified.

The service had a clear management structure. The two registered managers were supported by two directors of the company and an external care professional who is a nurse. There was a nurse who was in charge of each of the two units.

The home had a communication system. Hand-over meetings took place at the beginning and end of each shift. There was a day to day diary with information for care workers and a daily allocation book. Care workers informed us that there were also team meetings where they were informed of issues related to the

management of the home. They stated that they found their managers approachable.

There was a range of policies and procedures to ensure that care workers were provided with appropriate guidance to meet the needs of people. These addressed topics such as infection control, safeguarding and health and safety.

The company had started their new satisfaction survey in 2019. We saw that some completed forms had been returned. These indicated that people and their representatives were mostly positive regarding the questions asked which related to meals provided, the behaviour of staff, their environment, privacy and dignity and activities provided.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider did not ensure that all people receive appropriate care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to provide adequate risk assessments which included guidance to care workers for managing risks to all people who needed them.