Bestcare Ltd

Vishram Ghar

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 30 October 2018 and was unannounced.

At our last comprehensive inspection on 25 January 2018, we rated the service as requires improvement. This was because risk assessment lacked detail and sufficient guidance for staff to keep people safe, medicine records were not always completed accurately, staff did not always follow safe infection control, people did not receive consistent support with their meals, there were limited opportunities for hobbies and activities and systems for monitoring the quality of the service was not effective in bringing about improvements. At this inspection we found the provider had made significant improvements to address these shortfalls, although further improvements were needed to ensure people were consistently safe.

Vishram Ghar 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.

Vishram Ghar accommodates up to 44 older people across two separate units, each of which have separate adapted facilities. One of the units specialises in providing short term care to people who are under assessment following illness, injury or hospital discharge. The second unit support people who require long-term care, some of who were living with dementia. At the time of our inspection there were 39 people using the service.

A registered manager was in post at the time of the inspection. 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.

There were enough staff to meet people's needs. However, staff were not always deployed effectively to provide people with consistent support and engagement.

There were improvements to protect people from the risk of infections. However, these were not fully embedded into all staff working practices.

Staff understood how to protect people from the risk of abuse and procedures that should be followed to report suspected abuse. People had risk assessments in place to cover any risks that were present within their lives, whilst also enabling them to be as independent as possible.

There were safe systems in place for the administration of medicines and people received their medicines as prescribed.

Staff recruitment procedures ensured that appropriate pre-employment checks were carried out to ensure

only suitable staff worked at the service.

People received effective care and support from staff that had the skills and knowledge to meet their needs. Staff attended training where they completed mandatory training and received on-going training to enable them to fulfil the requirements of the role. Staff felt well supported by the registered manager and deputy managers.

People were able to choose the food and drink they wanted and staff supported people with this. Further development of the meal service was planned to ensure the serving of meals was efficient. Staff supported people with health appointments where necessary. Health professionals were involved with people's care as and when required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Policies and systems in the service supported this practice. People were encouraged to make decisions about their care, daily routines and preferences. Staff worked within the principles of the Mental Capacity Act 2005.

People were cared for by a staff team who were friendly, caring and compassionate. Positive relationships had been developed between people and staff. People were treated with dignity, respect and kindness.

People were involved in their own care planning as much as they could be, and were able to contribute to the way in which their care was provided. Care planning was personalised and reflected people's wishes and preferences, so that staff could understand their needs fully. People were in control of their care and listened to by staff. Care records were regularly reviewed to ensure they reflected people's current needs.

People had access to activities and were supported to go out into their local community. The registered manager was developing contingency plans to ensure activities were always available in the absence of the activity co-ordinator.

The provider encouraged people and relatives to share their views about the service. Complaints were responded to in a timely manner and used to drive improvements in the service.

Quality monitoring systems and processes were in place and comprehensive audits were taking place within the service to identify where improvements could be made.

The service worked in partnership with other agencies to ensure quality of care across all levels. Communication was open and transparent, and any improvements were highlighted and worked upon as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff were not always deployed effectively or safely to provide appropriate supervision and engagement for people.

There were improvements in systems and processes for preventing the control of infection but these were not consistently followed by staff.

There were risk assessments in place to mitigate any identified risks to people.

People were protected from abuse and harm by staff who knew their responsibilities for supporting them to keep them safe.

The provider had robust systems in place to ensure lessons were learnt from incidents and accidents in the service.

There were safe systems in place for the administration of medicines and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

People received support from staff who had the skills and knowledge to meet their needs.

People were supported to make decisions and choices about how their care was provided.

Staff enabled people to access appropriate healthcare services and supported people to have sufficient amounts to eat and drink.

Is the service caring?

Good

The service was caring.

People were treated with dignity, kindness and respect by staff who recognised and protected people's diversity and right to

equality.

Staff supported people and their relatives to be involved in planning their care and making decisions about how their care was provided.

Is the service responsive?

Good

The service was responsive.

People received care that met their needs and records were up date and regularly reviewed to ensure they reflected people's current needs.

People were able to participate in activities, though these were not always provided consistently.

People had information on how to make complaints and the provider had systems in place to deal with complaints.

Is the service well-led?

Good

The service was well led.

The registered manager was developing an open and inclusive culture focussed on providing personalised care.

Systems and processes were continuing reviewed and developed to ensure effective systems in place to monitor the quality of the service and action was taken whenever shortfalls were identified.

People, relatives and staff were encouraged to give their feedback and be involved in the development of the service.

Vishram Ghar

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This unannounced, comprehensive inspection took place on 30 October 2018 and was undertaken by two inspectors and one 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.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We received the completed document prior to our visit and reviewed the content to help focus our planning and determine the areas we needed to look at during our inspection.

We reviewed the information we held about the service, including statutory notifications. A statutory notification is information about important events that the provider is required to send us by law. We also reviewed information provided by the local authority, responsible for funding some of the people who used the service.

During our inspection we spoke with seven people who used the service, five relatives, the registered manager, the provider, two deputy managers and five care staff. We spent time with people who used the service and observed care and support in communal areas. This helped us understand their experience of using the service. We observed how staff interacted and engaged with people during individual tasks and activities.

We reviewed records relating to the care of five people, medicines records and storage, minutes of meetings and complaints. We also reviewed four staff recruitment records, staff training records and other records related to the management and governance of the service, including quality assurance.

Requires Improvement

Is the service safe?

Our findings

At out last inspection in January 2018, we rated this service as requires improvement in this key question. This is because risks assessments had not always been reviewed in a timely manner to ensure they reflected people's current needs. Staff were not always following procedures to manage and prevent the risk of infections for people. At this inspection we found the provider had made significant improvements in the standard of recording; further improvements were needed to staff working practices.

Risks to people's health and well-being had been assessed. People's care plans included comprehensive risk assessments that had been created to identify risks that were present for each person. Risk assessments were personalised, focussed on supporting people's independence and clearly explained how staff should support people. This included the support people needed to move around the service and reduce the risk of falling or injuries, risks associated with health conditions and behavioural support plans. People and relatives told us they were kept informed of measures in place to reduce risks, as they were involved in discussions about risks and safety during reviews of care plans.

People were largely cared for in a safe and clean environment. During a walk around the building, we did note exceptions that were addressed immediately or referred to the provider for action. We saw exposed pipe work under two hand wash basins in toilets. The pipes felt hot to touch which could present a potential risk of scalding if people were to access them. One radiator cover had not been replaced following decoration from the previous day. A wardrobe in one person's room had not been secured and 'wobbled' when used, presenting a risk of falling onto a person. We found a glass mirror leaning on a window sill in a bathroom. The mirror was not secured and the corners were damaged and sharp. The mirror could have easily fallen if touched and presented a risk of injury for people. We removed the mirror and informed the registered manager of our findings. They told us they would take immediate action to address our concerns.

During our inspection we found the premises to be cold and some radiators were cool to the touch. We raised this with the registered manager who had contacted the provider. They told us a contractor was on the way to address a problem with the heating system. A contractor arrived during our inspection visit and took immediate action to rectify the problem.

Staff demonstrated awareness of infection control procedures. For example, wearing gloves and aprons and ensuring these were changed between tasks, such as personal care and supporting people to eat and drink. However, we saw exceptions to this. For instance, we saw several staff members wearing jewellery that was not in line with the provider's dress code. This included large hoop ear-rings and bracelets that were not covered when staff supported people or served food. We saw most staff wore gloves when serving food for people. However, we observed one staff member serving slices of apple to people by handed them out to people from a bowl. They did not wear gloves. These examples demonstrated instances where staff were placing themselves and people at risk of injury or cross infection. We raised this with the registered manager who told us they would follow these examples up with staff.

People and relatives shared mixed views about whether there were enough staff deployed in the service to

keep people safe and meet their needs. Comments from people included, "Staff are always here when we need them," "Staff numbers are alright. Usually they [staff] come within five-ten minutes when I ring the bell. If they are busy, they say and they come back soon," and "There are plenty of staff here. It's the same at night time." A relative told us, "There are always staff about." However, a second relative told us there wasn't always enough staff around. They told us, "Sometimes when I visit there are no staff in the lounge. It's unattended and risky for the people with dementia in here. Sometimes when staff are short then people are having to wait. It happens now and then."

Staff also provided mixed views on whether there were enough staff available. Staff comments included, "There are enough care staff. More than in other homes I have worked in," "There are usually enough staff but sometimes not enough if a person needs extra help. It can be very busy," and "There is mostly enough staff but only to meet people's needs, such as personal care and mobility. We don't have as much time to spend doing non-care things with people, like talking or activities."

During our inspection visit, we observed there were enough staff to support people to move around the premises. Staff were attentive in ensuring people received support with personal care and assistance to eat and drink, though staff were very busy and were rushing around. There was mostly a staff presence in communal areas, though staff were engaged in completing records and only chatted briefly with people sitting in the lounges. There were short periods of time when staff were supervising lounges from corridors whilst they were supporting other people.

Staffing levels were regularly assessed by the registered manager by using the provider's staffing dependency tool. The registered manager told us they regularly reviewed staffing levels to ensure they were sufficient to meet the needs of people using the service. Staffing rotas demonstrated that care staffing levels matched the most recently assessed dependency needs of people using the service. We discussed the effective deployment of staff around the premises with the registered manager. They told us they would review this to ensure staff were always sufficiently deployed around the premises to keep people safe and ensure people were appropriately engaged.

People told us they felt safe using the service. Comments included, "I have not had any falls and there isn't any bullying by staff, " "It's safe, the staff are alright. I like it here, the staff are very loving," "I am safe from falls here. These is always someone to help me," and "We have no problem here for safety. The staff are very good." A relative told us, "The home is generally safe. Sometimes I have seen staff being off hand with residents, just the manner they speak, but I have seen no wrong actions." Another relative told us, "I do not worry about [family member]. They are safe from accidents. I have never seen or heard anything concerning when I visit." We observed that staff appeared comfortable with the support provided by staff.

Staff demonstrated they understood how to keep people safe. For example, we observed staff help people to move using equipment, such as hoists and rotunda frames. This was done safely and in line with good practice. Staff ensured people had access to their mobility aids and supported people to walk at their own pace without rushing them

People were protected from the risk of abuse. We talked with staff about safeguarding people from abuse and they demonstrated they understood the correct procedure to follow. One staff member told us, "People are safe here. I speak two Asian languages so I can communicate well with people and understand if they have any concerns." A second staff member told us, "I know what is wrong and what is right. Any worries or concerns, I would report straight away." Staff had attended safeguarding training to protect people from harm and abuse. Staff were aware of how to raise concerns about potential malpractice in the service, referred to as whistleblowing. The provider's safeguarding and whistleblowing procedures supported staff

to understand how concerns would be responded to and managed and provided details of external agencies they could contact for support.

The registered manager understood their responsibilities to notify external agencies of potential safeguarding incidents. Records showed they had made appropriate notifications and involved external agencies in reviewing incidents where people had come to actual or potential harm. This enabled agencies to ensure appropriate action had been taken and measures had been put in place to safeguard people from the risk of further harm as far as possible.

Recruitment checks had been consistently and safely carried out in accordance with the provider's policy. Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references, proof of identify and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working in care and support services. A staff member told us, "My DBS was done (before I started). The registered manager had references for me and I did a medical form."

People told us they received their medicines as prescribed and had confidence that staff had the training and knowledge to administer medicines safely. Comments included, "They [staff] give my tablets every day; no problems there," and "I get my medicines from the senior staff and they give them me at the right times. I take them myself and they write it down." We observed staff supporting people to take their medicines. They explained to each person what their medicines were for and waited to make sure people had taken their medicines before recording on medicine administration records (MARs). We saw staff administering medicines wore a 'do not disturb' tabard so they could concentrate on giving people their medicines safely. Staff told us they were provided with training on the safe handling, recording and administration of medicines in addition to specialist training, for instance in administering insulin. One staff member told us, "The district nurse did my training and assessed me as competent." This was confirmed in the training records we reviewed.

People's care plans included a one-page profile with a photograph of the person, detailing the support they needed to take their medicines. The profile also included any specific information staff needed to be aware of, such as allergies. Where people were prescribed medicines to be taken as and when required, these were supported by protocols which guided staff on when and how the medicines should be administered. We saw staff consulted with people to determine if people needed these medicines, for example, pain relief. Body maps were in place for topical medicines, such as creams or transdermal medicines that are applied directly to the skin. There were rotation charts in place for transdermal patches. However, records did not enable staff to record if checks had been made to confirm patches remained in place in between doses, which could be up to five days. The deputy manager told us they would ensure checks were made and recorded in MARs charts following our inspection.

Medicines were stored safely and temperatures of storage areas were monitored daily which helped to ensure medicines were stored safely at recommended temperatures. The registered manager had made improvements to the monitoring, auditing and checking of medicines since our last inspection. This helped to ensure medicines were administered accurately and correctly and people received medicines safely.

The provider was in the process of undertaking work to upgrade the premises. This included replacement of fittings and redecoration. The provider had recently replaced all doors with approved fire doors and was in the process of overseeing replacement lighting in communal areas and decoration of people's rooms at the time of our inspection. The registered manager completed monthly audits on the environment to identify

any risks. They told us they would ensure systems were in place to monitor and check the potential risks people were exposed to whilst the premises was being upgraded.

Regular maintenance and equipment audits relating to fire safety records, maintenance of safety equipment, gas safety, call systems and portable appliance testing (PAT) were undertaken. Contingency plans were in place in case the premises needed to be evacuated and each person had a Personal Emergency Evacuation Plan (PEEP) in place to provide information to emergency services in the event of an evacuation.

There were arrangements in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. For example, falls were analysed to identify any contributory factors that could be assessed. This included reviewing the footwear of the person and reminding people to summon assistance so they were appropriately supported by staff when they moved around the premises.

Good

Is the service effective?

Our findings

People and relatives told us they thought the care provided was effective in meeting people's needs. One person told us, "It is good here. I don't want to go anywhere else." A relative told us, "It is very good here. [Name of family member] is well looked after. Within a week they were really settled. They are happy here."

People received a comprehensive assessment of their needs before the service agreed to provide their care and support. This ensured staff had the information they needed to meet people's needs, and people were involved and informed to make decisions about how they wanted their care to be provided. Assessments were used to develop care plans which included a one-page profile that summarised people's needs and preferences.

Staff told us they had completed training to ensure they were competent and had the skills and knowledge to meet people's individual needs. One staff member told us, "I have done moving and handling, infection prevention and health and safety training recently." New staff received an induction, which included shadowing experienced staff. This enabled them to get to know people and how they preferred their care to be provided prior to supporting them. One staff member told us, "My induction training gave me an overview of the home. this included getting to know people and staff and the policies and procedures. I had previous care experience and vocational qualifications." A second staff member told us, "My induction was good and I worked alongside experienced staff to get to know them. The one page profiles in people's care plans really helped me to understand about people's needs and how care should be provided."

Training records we reviewed showed staff had completed a range of training relevant to their role and this was monitored through a training matrix, a central record of training staff have completed, to ensure it was kept up to date. New staff were supported to work through the Care Certificate; a nationally recognised qualification which covers the fundamental standards expected of staff working in care.

Staff told us they had regular supervision. Staff comments included, "I have supervision every four to five weeks. I feel very supported in my job," and "I have formal supervision every six to eight weeks. If I need anything in between, I 'bend' the [registered] manager's ear." The registered manager told us they had fallen behind with some staff supervisions so these had not been held as regularly as they wished. They told us they were in the process of scheduling supervisions to ensure these were up to date.

People told us they were mostly happy with the quality of meals provided. People's comments included, "The food is okay and we get a choice. I'm a vegetarian. The food is warm enough. If I'm hungry I can get extra," "I'm Gujerati. The food is good, ten out of ten. It's tasty and warm and they [staff] give me more if I want it," and "The food is good but it's the same food every day. I don't eat pork or beef. You get meat if you are lucky. You can also get snacks and drinks when you want." A relative told us, "I was worried that English food would not be available and [family member] would not like the food. This is not the case. [Family member] is served the food they like."

The provider had recently undertaken consultation with people and their relatives regarding menu choices.

This had resulted in an extensive menu that tried to cater for wide range of cultural and personal preferences. We observed the lunchtime meal to identify the impact of improvements as a result of consultations. We saw staff served people a range of dishes, such as rice, salad, lentils, vegetables and yoghurt. People were offered a choice of dishes and quantities and were provided with drinks during their meal. This process was extremely time consuming and resulted in some people finishing their meal before the final dishes were offered. We saw a large amount of food was not consumed by people. Staff did approach people to check they had had sufficient amounts to eat. Most people ate traditionally with their fingers. Staff brought a jug of water and bowl for people to rinse their hands and dry with a paper towel, reflecting people's preferences in how they ate and demonstrating respect for people in line with cultural traditions.

The dining areas were divided into two separate rooms to cater for people who followed a strictly vegetarian diet and those who followed non-vegetarian. We saw there were two kitchens to prevent any meat or other products contaminating vegetarian food products. Tables were sparsely laid and there was limited conversation and ambience within the dining rooms.

We discussed the meal-time experience with the registered manager who explained extensive time had been spent trying to offer people as much choice as possible. This had made meal times complex and time consuming. The registered manager told us they would review the process with the provider to find a balance between choice and an enjoyable and efficient dining experience.

Where people required support to eat and drink, staff provided this sensitively. They sat with people and supported them to eat and drink at their own pace. Specific dietary needs were catered for, such as soft diets, and staff followed health professional guidance for people who required specialised diets to manage their health conditions. Where people were at risk of poor nutrition, staff monitored and recorded food and fluid intake. We saw records were up to date and staff recorded actual amounts consumed, although some records were not accurately totalled to demonstrate people's total daily intake. The deputy manager told us they would ensure records were completely accurately.

People had access to the healthcare support they needed. One person told us, "I see my doctor and have my eyes tested." A second person told us, "The doctor comes every Monday and checks my medicines." A third person described how staff recognised the person wasn't well and sought appropriate healthcare for them with the result their health had improved. The service provided five assessment placements which were available to enable people's needs to be assessed and measures put in place to support people to return to their own homes following injury or change in needs. Staff told us they worked in partnership with a range of health professionals, including occupational health therapists, community mental health services and physiotherapists. This was confirmed in records we reviewed. Guidance and advice from health professionals was included in people's care plans and records showed staff followed this when they supported people. Care plans also included an explanation of people's health conditions, such as diabetes, which further supported staff understanding and knowledge.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the

Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We saw that MCA and DoLS authorisations were completed as required and best interest meetings were held to determine the best course of action for people regarding specific decisions. Records confirmed conditions in authorisations were complied with.

People told us staff always sought consent before providing care and support. One person told us, "They [staff] explain. Like they ask me if it's okay to put some cream on. They explain that I am moving into a wheelchair and check it's okay to help me with things." A relative told us, "I notice staff ask before using the hoist and tell [family member] what they are going to do. Staff ask if [name] is okay and wait for [name] response." We observed staff asked people before supporting them with tasks. Staff demonstrated they understood people's right to decline their care. One staff member told us, "If someone doesn't want something, we respect it. Just because they are living with dementia doesn't mean they can't make decisions about their care." People's care plans detailed the support people needed to make decisions which enable staff to offer appropriate support and ensure people had equal opportunity to make choices and decisions.

The provider was in the process of undertaking refurbishment and redecoration to areas of the premises to ensure it was suitable for the needs of the people using it. Areas that had been completed were bright and included signage to enable people to recognise key rooms, such as toilets, bathrooms and lounges. Where people had consented, people's names or a photograph had been put on their door which supported people to orientate around the premises. People were encouraged to personalise their rooms and had brought in personal items from their own home which helped to make them feel more settled.

Good

Is the service caring?

Our findings

People spoke positively about the staff and the care they provided. Comments included, "The staff are good. They are brilliant. I like them. They come quickly when I need them," "They are good, understanding and give me love and kindness," "They talk to me with my name and I know all their names," and "I have a keyworker I can talk to about my needs. Staff ask me what I want when I call them."

We saw staff interacted with people in a positive and friendly manner and clearly knew people well. When people appeared anxious or worried, staff communicated with them and provided reassurance. We saw that staff understood the individual signs and reactions that people demonstrated to indicate their feelings or responses and addressed people by their preferred name or term of address, demonstrating respect for people's preferences and cultural traditions. This demonstrated staff knew people well and understood the importance of protecting people's right to be treated equally whilst respecting diversity.

People and relatives told us they had been involved and consulted in the development of their care. One person told us, "I talked with staff about what I needed. They do what we talked about." A relative told us, "I am and always have been involved in the care planning. Staff ask my views and listen to me and I can look through the care plans at any time." People's life history and wishes were considered as part of their care and this information was included in people's care plans. For example, if people followed active worship, likes and dislikes. This helped to support staff to develop meaningful relationships and conversations with people.

If people were unable to make decisions for themselves and had no relatives to support them, the registered manager was able to support people to access advocacy organisations. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive.

Staff spoke of people they supported in a caring and compassionate way. They were able to discuss people as individuals and were aware of people's needs, including specific routines that were important to people.

Visiting times to the service were open and flexible, but visitors were encouraged to avoid visiting at meal times, referred to as 'protected mealtimes.' This was to support people to eat without disruption and enabled staff to focus on mealtimes. We saw visitors came and went from the premises and were greeted by staff upon arrival. One relative told us, "I come and visit every day. I am always made to feel comfortable."

People were supported to be as independent as they were able to be. For example, staff supported people to use mobility aids and do as much as possible for themselves before stepping in to provide assistance. Staff spoke politely to people and protected people's dignity. Staff knocked on doors before entering and checked with people whether they were happy for them to enter. We observed staff discreetly supporting people to adjust their clothing to preserve their dignity.

People's care records and personal information was kept securely and the provider had a confidentiality

policy. Records showed information was only shared with people's consent and on a need to know basis.

Good

Is the service responsive?

Our findings

People had care plans in place which contained detailed information about how people wanted their support to be provided. This included information such as people's background history, any cultural or religious requirements, likes and dislikes and things that were important to the person, such as people or routines. For example, for one person it was important for them to observe worship and key celebrations of their faith. Another person liked to have particular music playing in their room. Night time routines included what people liked to wear, how many pillows they preferred, bedclothes, drinks and lighting. This information helped staff to provide personalised care.

The registered manager had recently completed an extensive process to review and update all care plans. This included a one-page summary as a source of reference for staff. The registered manager told us, "I have developed the care plans recently; it was a huge task. I involved people where possible and their relatives in producing individual care plans." Staff spoke positively of the one-page summary as a useful point of reference, particularly for new staff who were learning about people's needs and preferences.

Care plans had been reviewed to ensure they reflected people's current needs. People and relatives told us they had been involved in theses reviews. One relative told us, "I always attend reviews of [family member] care plans and records. We are asked our views on all issues." Care plans reflected changes in people's needs. For example, one person increasingly received care from their bed and their care plan had been reviewed and updated to reflect this. Care records showed staff had responded to this change in needs through the care they provided.

People were encouraged to take part in activities, though these were not provided consistently. The provider had employed a full-time member of staff dedicated to providing activities, although there was no provision for activities in their absence. On the day of our inspection, the activities person was absent from the service. A staff member told us, "If the activities person if on a day off, there are not activities as we don't really have time. People do get bored." People told us, "Sometimes I do gardening here when the weather is good," "I join in the singing groups and enjoy the 1930's Asian films," and "We can do bingo, exercise with balloons, sing and do prayers." We saw Halloween decorations in the dining room which people had made in preparation for a Halloween party. Staff told us there was a trip arranged in the next few days to celebrate Diwali and people were supported to attend a temple on Fridays and Mondays.

The activity co-ordinator liaised with people to identify the activities that they would like to be provided. Relatives told us their family member sometimes joined in, but many preferred to sit and watch. A senior staff member told us the activity co-ordinator had awareness and understanding of activities for people living with dementia, but this was not reflected through any planned activity schedule or in records of activities provided. Records did not identify how people were engaged and stimulated where they required support to do this. The registered manager told us they would follow this up.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it to comply with the Accessible Information Standard (AIS). the AIS is framework put in

place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information. We saw there were examples of information transcribed into different languages and details of how people preferred to receive information.

People were encouraged to raise any concerns or complaints and told us they were confident to do so. One person told us, "If there is a problem I can ring the bell in my room and tell the staff the problem and what is bothering me. If it is a big problem, then I would talk to the manager. She will listen. I have made no complaints." Relatives told us if they had any concerns they just tell staff straight away and they listen and resolve the issue. They told us they had not needed to make formal complaints but would speak to the [registered] manager if they needed to. The provider's complaint policy was clearly displayed and supported people to raise complaints and understand how these would be dealt with. Complaints received had been dealt with appropriately and were logged and monitored. It was clear that, where possible, action had been taken to ensure improvements were made, such as installation of equipment or clarification of the care provided.

The provider had policies and systems in place to support people to make decisions about their end of life care. Staff had received training in supporting people with end of life care and were able to liaise with other agencies, such as district nurses, to support people with their final wishes.

Good

Is the service well-led?

Our findings

At our last inspection we rated the well-led domain as requiring improvement. This was because systems in place were not effective in making sure a quality service was provided at all times. At this inspection, we found the provider had made improvements to ensure systems were effective in monitoring and checking the service. Further improvements were planned and on-going. The registered manager provided assurances that the shortfalls we identified at this inspection would be addressed as a matter of priority.

The quality assurance process was more detailed and actions were taken in a timely manner. Regular performance and compliance audits and checks were conducted and they reviewed areas such as care records, staffing, infection control, medicines, complaints and governance. Outcomes of audits and checks informed action plans and these were used to drive improvements in the service. For example, action plans from environmental audits had resulted in a redecoration programme throughout the service and upgrade of fixtures and fittings. Audits of care records had resulted in the registered manager developing one-page profiles to support staff understanding of people's needs and wishes. The registered manager was able to demonstrate further improvements were planned, including the use of technology within the service.

People and relatives spoke positively about the registered manager. Comments included, "The registered manager is very approachable, as are the other office staff," "[Registered manager] says hello to me (in the person's first language) and I can tell her if I am worried. I told her when [family member] was sick and asked for staff one-to-one and they did that," and "It is run well. They [staff] meet people's needs. People are kept clean and tidy and there are good routines." The registered manager was supported by two deputy managers. Both the registered and deputy managers had a visible presence in the service.

Staff told us they felt supported by the registered and deputy managers. One staff member told us, "I feel I can go to the registered manager or deputy managers if I need to as they are approachable." Another staff member told us they felt able to approach the registered manager and felt the deputy managers' were very supportive. The operations manager had recently developed a staff survey. They told us the aim of the survey was to enable staff to share their views about the service in confidence. Feedback from the surveys was being collected which the provider hoped would help to identify key areas where staff felt the service needed to improve. The operations manager told us an action plan would be developed and shared with staff to enable them to see their feedback mattered and was important to develop the service. Staff were also supported to provide feedback through staff meetings. A staff member told us regular meetings were held for staff and these were helpful. They told us, "We are given information and can make suggestions. I asked for some more training and this was organised." Meetings were recorded in English and Gujarati to ensure information was shared effectively with all staff.

Staff told us they enjoyed their jobs, worked well as a team and were respectful of the diversity within the staff team. One staff member said, " I can speak one Asian language. Staff speak many Asian languages and there are many different cultures. You can't know everything, so we support each other to communicate with people."

The registered manager strived to develop a culture of openness and transparency. People were encouraged to provide feedback on their experience of the service. People and relatives told us there were regular meetings where they could make suggestions and were consulted about proposals. One person told us, "We have resident meetings and people come to talk to residents. We talk about having different food and the decorations. The food has improved (as a result of feedback)." Another person told us, "We can speak our mind. If the food is bad, we say so. We all meet together with staff. The kitchen staff come in as well." A relative told us, "We discuss activities, like cultural and religious events." The operations manager had focussed on consulted people about the meal provision to bring about improvements in the quality and choice of meals provided.

We saw the service worked in partnership with other agencies and stakeholders in an open and honest way. They shared information, as appropriate, with health and social care professionals; for example, local authorities involved in commissioning care on behalf of people, safeguarding agencies and community health teams. This helped to ensure that people received a joined up approach to their care and support.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. We refer to these as notifications and we found the registered manager had sent appropriate notifications to us. It is a legal requirement for providers to display their ratings. The rating from the previous inspection was displayed for people to see.