Best Care Limited

Vishram Ghar

Inspection report

120 Armadale Drive
Leicester
LE5 1HF
Tel: 0116 2419584
Website: www.mahesh@pattani.plus.com.co.uk

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 23 October 2014 and was unannounced.

Vishram Ghar provides accommodation and personal care for up to 40 people accommodated over two floors. This includes care of people with mental health or physical health needs. On the day of the inspection 40 people were living in the home. 16 people had a diagnosis of dementia and seven people received nursing care in bed. The service primarily supports people from Asian communities.

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

People's care and support was not always planned and delivered a way that met their individual needs. Risks associated with people's care were not always assessed and action was not always taken to reduce these risks.

People told us that any complaints, concerns or issues they raised were not always dealt with, in order to improve the service they received.

Summary of findings

Systems in place for checking the quality and safety of the service and the care people received had not identified a number of shortfalls in the care and service provided. This meant that a number of issues had not been addressed for the benefit of people who lived at the home.

Staffing levels had recently been increased and were under further review in order to ensure that staff were available at the times people needed them.

Staff had received training on how to protect people who used the service from abuse or harm. They demonstrated they were aware of their role and responsibilities in keeping people as safe as possible.

Satisfactory pre-employment checks had been carried out for most staff. This meant people were protected from the risk of unsuitable staff.

People were given sufficient food and drink to meet their dietary needs and had a choice of what food they were given.

Most people were supported to maintain their health needs. In most instances referrals were made to health care professionals for additional support or guidance if people's health changed.

The Mental Capacity Act (MCA) is legislation that protects people who may lack capacity to consent to their care and treatment. Not all staff knew how to protect people under this legislation.

The provider supported staff by an induction and some on going support, training and development. However, comprehensive training had not been provided to staff. Plans were in place to address this. Staff told us that they were well supported by the registered manager and were able to put forward suggestions about how the service was run during staff meetings.

People who lived in the home and relatives told us they found staff to be caring, compassionate and respectful. Our observations found staff to be kind and attentive to people's individual needs and preferences and ensured that their dignity was maintained.

People were supported to pursue their hobbies, interests and faith and maintain relationships with people important to them.

People who lived in the home and their relatives were encouraged to participate in discussions and decisions about the care and support provided. This also included sharing their views and experience of the service

People who lived in the home had been asked to share information that was important to them about how they wished to have their needs met. This included information about routines, preferences, interests and hobbies.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

Risk assessments, designed to keep people safe, and plans of peoples' care, had not always been followed or reviewed regularly.

Staff were not always available at the times people needed them, however staffing levels were under review.

Staff were aware of how to report concerns to relevant agencies if the service had not acted properly to protect people.

Recruitment procedures designed to keep people safe had been correctly followed most of the time.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported by staff who received appropriate training. Plans were in place to address this.

People and their relatives told us that overall they received good care.

Where people lacked the capacity to make their own decisions, assessments and 'best interests' meetings had not always taken place.

People told us that the food was good. People were provided with appropriate assistance and support and staff understood people's nutritional needs.

Most people had been referred to relevant healthcare professionals in a timely manner.

Is the service caring?

Good

The service was caring.

Most people and their relatives said staff were kind and caring, treated them with dignity and respected their choices. This was confirmed by our observations.

People and their relatives told us that they were involved in decisions about their and their family's member's care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all complaints had been recorded and, therefore had not all been responded to appropriately.

Staff had a good understanding of people's care needs and preferences. However, this information was not always included in people's plans of care.

Summary of findings

People were supported to pursue their hobbies, interests and faith and maintain relationships with people important to them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems in place for checking the quality and safety of the service and the care people received had not identified a number of shortfalls in the care and service provided.

Staff told us that they were well supported by the registered manager and were able to put forward suggestions about how the service was run during staff meetings.

Vishram Ghar

Detailed findings

Background to this inspection

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

This inspection took place on 23 October 2014 and was unannounced.

The inspection team consisted of two inspectors and an Interpreter. This is a service for Asian older people, the majority of whom have a first language other than English.

Before the inspection, we asked the provider to complete 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. They did not return a PIR and we took this into account when we made the judgements in this report.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with the registered manager, the area manager, five care staff and the cook. We also spoke with seven relatives and nine people who used the service. We observed the lunch time meal service.

We looked at five people's care records and other records which related to the management of the service such as training records and policies and procedures.

We spent time observing care and support being delivered. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We found that proper steps had not always been taken to ensure that people were safe by ensuring that risks were accurately assessed and equipment was used correctly.

We saw that one person had a pressure relieving mattress on their bed which had been set for someone weighing 140kg. A senior member of staff checked the record of weights for this person and told us that they weighed 34.20kg. Incorrect settings on pressure relieving mattresses would increase the risk of people developing pressure ulcers. The member of staff altered the mattress setting during our inspection to reduce the risk. She confirmed the settings on other pressure mattresses would also be checked.

One person said that staff had not always been helpful. They stated they had an accident because staff had not helped her to transfer to the toilet. The GP had not been asked to visit her. It was not until a district nurse called to see her to treat another condition a week later that medical professionals were contacted. She was then admitted to hospital for treatment. We looked at the home's accident records and found there had been a fall. However, there was no reference to staff contacting medical services.

The person also stated that staff did not provide appropriate food or fluids for the risks associated with their diabetes condition. We looked at the booklet for measuring their blood glucose level. This stated levels needed to be checked four times a day. We found that on occasions levels were only checked once, twice or three times a day. We found occasions when these recordings were above or below what was considered a safe level. There was no evidence as to what steps staff should be following in these situations. We looked at the care plan. We found there was no risk assessment for diabetes to assist staff to provide proper care for this person. The manager said she would follow these issues up.

We saw that some records relating to people's care contained conflicting or incomplete information which created a risk of inappropriate or unsafe care. For example, some records of GP visits did not include the reason for the visit, advice given, or details of medication prescribed.

We saw a clear care plan in place for staff to follow in the event of a seizure for one person with epilepsy. This included when to call for emergency services. Staff told us that no seizures had occurred recently but this person sometimes experienced "jerking". There was no record to show how often the seizures or the 'jerking' occurred. This meant that reliable information would not be available for health professionals when reviewing health and prescribed medication.

Although we found people's needs were regularly assessed, the way documentation was arranged meant there was risk that people may not always receive responsive care as consistent documentation was not in place.

The area manager told us plans of care and risk assessments should have been reviewed monthly. However some files had not been reviewed for over six months. Other documents, such as personal histories, were not always completed. The lack of clear information meant care staff may not be aware of changes in people's care needs which could lead to inappropriate or unsafe care or treatment.

This was a breach of Regulation 9, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with told us that they felt safe and would speak to the staff or manager if they had any concerns. One person said, "Yes, I feel perfectly safe here."

The provider had safeguarding policies and procedures in place. These were designed to protect people from harm. Staff we spoke with had a good understanding of their responsibilities in this and told us they would immediately raise any concerns with their line management. They told us that they were confident that the management team would then take action to report the concerns raised. If not, staff knew of relevant agencies to report their concerns to. There had been no safeguarding incidents reported to us for the previous 12 months.

We saw evidence of bruising to a person which had been noted in July 2014. This had not been reported to the local authority safeguarding authority, or to us. The provider has a legal duty to report such incidents to both CQC and the local authority. The manager apologised for this omission and stated that all such incidents would be reported properly in future.

Most people we spoke with had a diagnosis of dementia so they were not able to tell us whether there was enough staff at the home. However, staff members told us that there were not enough staff on duty from 3pm to 9pm to

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Is the service safe?

meet people's needs, when staffing levels reduced by two care staff from the morning period. Also that staffing numbers were insufficient at night as there were only two waking night staff on duty for 40 people. When we observed life in a lounge, we found occasions where no staff were present in the main lounge when people, who were at risk of falling had stood up unaided.

We spoke with the registered manager about staffing levels. They told us they had improved staffing levels and were currently in consultation with the provider to increase staffing levels further, as it was recognised that the current staffing did not fully meet the needs of people in the home. When we returned to complete the inspection, we were told by the area manager that an additional member of night staff had been employed.

We looked at three staff files and found robust recruitment processes, designed to keep people safe, were not always followed. References were not always from previous employers. The manager stated this would be put in place for the future to ensure a more robust system.

We saw that a fire door had been wedged open, potentially compromising fire safety, so we looked at fire records. Fire alarm tests had been carried out at the required frequency. The fire extinguishers, we saw were up to date with servicing. A fire drill instruction had been carried out two months before this inspection. However, there was a recommendation in the independent health and safety report the provider had commissioned in January 2014 that stated that a fire drill for the night staff was needed. There was no evidence this had happened. The manager recognised this lack of instruction for staff was a risk to people. She later confirmed to us that a fire drill had been arranged and had taken place within two days of this inspection.

The manager said she would ensure that unannounced fire drills would be carried out on a regular basis and staff would participate in at least one fire drill a year. This would help them prepare if there ever was a fire.

We asked people about their medicines. No one reported any problems with getting their medication from staff.

Requires Improvement

Is the service effective?

Our findings

Staff told us that daily handovers took place so that staff could update the next staff on shift about people's needs and if any changes in their care had been identified. Staff we spoke with told us the handover was a good source of information and helped them to meet people's needs.

The nutritional assessment for one person showed that they had been assessed as being at low nutritional risk. However, the assessment was not an accurate reflection of their current health needs. Records showed that between February and August 2014 this person had lost 4kg in weight. No records of weight were available from August 2014 and a member of staff told us that another member of staff had the most recent weight record at their home, as they had accidentally taken it home. They told us that this person's weight had dropped further. The medication administration record for this person contained a handwritten entry for a food supplement, which staff said had been prescribed by the GP, due to the person's weight loss. With the exception of two days between 06 and 23 October 2014 this record showed that the food supplement had been refused. Staff told us that there had been no involvement from a dietician and there was no evidence that the GP had been informed of continued weight loss or the person's refusal to take the food supplement.

We spoke with staff who told us they had been aware of this care plan and would always encourage the person to eat. We spoke with the cook who told us if someone had not eaten they would offer them something else. The manager would be informed. The cook was aware of people who needed their meal pureed and was aware of some people who needed encouragement to eat. However they had not been asked by management to provide meals with additional calories because of weight loss.

We saw that staff supported people who needed help at mealtimes. The dining room was spacious. We observed that people were relaxed and staff were talking with them while assisting with their meals. Most people told us that they liked their meals and that their cultural needs had been taken into account.

We spoke with the cook who had a good knowledge of people's cultural and individual needs. We saw that the menu did not include a choice of meals; however the cook gave us examples of other dishes that were prepared to meet individual preferences. For example, one person who had not been eating well, liked a dish called 'hotch potch' at tea time. People confirmed that if they did not like the food offered the cook would prepare something else for them.

We saw that meals and meal times were flexible. One person told us they were not hungry at lunch time and we saw that they were served a meal during the early afternoon.

CQC is required by law to monitor the operation of the Deprivation of Liberty safeguards (DoLS). We found staff were not certain how to help people with limited capacity to make decisions. Staff told us there were people who had been encouraged not to leave the service unsupervised because they were assessed as being unsafe to do so. The manager told us that there were no Deprivation of Liberty Safeguards (DoLS) orders in place despite there being people with limited capacity to make decisions owing to their dementia conditions. There was one application made to the supervisory body to legally allow any deprivations of liberty though this had expired. The manager acknowledged that the proper process had not been fully followed and she would ensure that this was done.

A system was in place to provide staff with training. We looked at the training matrix, which showed the training staff had undertaken. Staff had not always been provided with training in line with the provider's annual training programme. This meant they may not have the latest knowledge and skills in key topics needed to deliver effective care.

Staff told us they thought the training provided equipped them to provide good care. However, we found although staff had received safeguarding and food hygiene training, not all staff had training in essential areas such as pressure ulcer prevention, continence care, first aid, mental capacity and DoLS, challenging behaviour and several health conditions. This meant people may be put at risk as the provider did not ensure staff had received appropriate training to meet people's needs. The manager and the area manager stated they would follow this issue up and ensure staff had all the training they needed.

Most people told us they could see the GP and district nurse as they needed. Plans of care recorded visits from health professionals. We spoke with one person who told

Requires Improvement

Is the service effective?

us that if they were ill an ambulance would be called and their relatives informed. A relative confirmed that staff responded to changes in health promptly by contacting medical services and always kept them informed.

Good

Is the service caring?

Our findings

People told us that staff were “Kind” and one person said, “Whatever you want they bring.” People told us that staff communicated in a language that was familiar to them, which for most people was Gujarati.

We saw that interactions between staff and people who lived in the home were caring and respectful. One person told us that the way that staff addressed them showed respect. People told us that staff respected their privacy. One person told us that staff understood that they could not see. Staff supported them by running the water in the shower for them and then leaving them to have some privacy while showering.

People we spoke with said that staff were kind and always made sure they were covered when personal care was supplied. We observed staff hoisting a person from their chair to a wheelchair for lunch. This was completed with consideration and the person’s modesty was maintained. We observed staff knocking on doors and waiting before entering to preserve people’s privacy.

During our inspection we saw that people were visited by relatives. Staff told us that some relatives had made a special point of visiting because it was the first day of Diwali (the Hindu festival of light). We spoke with relatives who said they visited regularly and were made very welcome by staff. They told us that all the main religious festivals of their religion were properly observed by the service.

Relatives we spoke with said they had the opportunity to be involved in people’s care reviews and that they had seen plans of care for their relatives which reflected the care needed. They said that the staff worked hard and their relatives were well cared for. We saw people smiling and enjoying contact with their relatives. We also saw one person assisting their relative with their lunch.

We observed that staff were calm and patient and explained things to people well. However, staff tended to concentrate on one person at a time and ignored other people, rather than greeting other people when they were close to them, to make them feel valued. The manager said this issue would be followed up with staff.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they knew how to make a complaint or who they could talk to if they had any concerns or worries. One person said "I am not worried about anything." However another person

told us they felt staff did not always listen to them. They gave three examples of issues they had raised that had not been acted upon. We found these issues had not been recorded. The manager said she had been on holiday during this time but she would follow up this complaint.

Feedback about whether complaints were dealt with appropriately was variable. For example, a person said that they had told staff that they needed to see a GP because their arm was hurting but staff had not acted on this request. The manager told us this was the first time she had heard about this concern and she would follow this up. She later confirmed that it had been investigated.

We asked staff what they would do if a person made negative comments about the service. They stated they would record these in the person's daily notes. This meant there was a risk of complaints not being properly followed up as they were not being recorded as complaints. This showed that the management of some people's complaints required improvement.

Staff said the main issues of complaints people had made had been about the laundry. We asked the manager if we could look at the complaints records. She said she had not been aware there had ever been any complaints, so no complaints had been recorded. This showed that complaints had been made but not followed up in terms of investigation and, therefore people had not received feedback and actions had not been taken in response to concerns they had raised.

This was a breach of Regulation 19 (complaints), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care records showed that their needs were assessed prior to admission to the home. However, this information was not always used to complete more detailed assessments to provide staff with the information to deliver appropriate, responsive care. These assessments included diet and nutrition and aiding with mobility. We did not see that information had been added to plans of care as appropriate. This indicated that as people's needs changed their package of care had not always changed. For example, whilst looking at accident records, we found someone had been found with a red patch on their skin. Actions had been documented on the accident record but no risk assessment was found to state what care was needed to prevent pressure sores developing. However, despite this, we spoke with three staff about people's preferences and care needs. They were able to tell us about the people they were caring for and what they liked and disliked.

We spoke with two people who spent time in their room. They told us that this was their choice, and that they went to the dining room for meals. They said they could have meals in their room if they wanted to. Care plans contained people's preferences for night time routines. We saw that these were detailed and included what people liked to wear, how many pillows, whether they wanted a light on and what they liked to drink. In people's care files we saw that they had been asked whether they had any preference as to the gender of the carer. This showed us that people's preferences had been respected.

People told us they were able to pursue their hobbies and interests. One staff member told us; "People can play games and do colouring if they want on most days." We saw that a range of activities were on offer throughout the week, arranged by the activities organiser. People told us that staff enabled them to access the community and maintain relationships with family and friends without restrictions.

We saw arrangements were in place to assist people to access events outside of the home. For example, we observed family members taking people home for the Diwali celebrations. Diwali is an important religious festivity and is the celebration of light for people who follow the Hindu and Sikh religions.

We observed people reading their newspapers. A person told us that they liked watching the TV in their own quiet corner of the lounge and they was able to select their own TV channel. We observed no other activities provided or how people were supported to pursue their hobbies and interests on the day of our inspection. However, people who lived in the home told us that there were activities

Requires Improvement

Is the service responsive?

arranged every day and they did not need any more. We saw an 'activities timetable' which outlined what the service provided. This told us they had been opportunities for people to join in with activities if they were interested.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we found that care documents related to people's care and support needs were not always comprehensive. This meant that there was a risk that people would not receive care and support that met their individual needs. The manager told us they had plans in place to update peoples' plans of care and risk assessments to ensure all information about people's needs was available to staff. However this had not yet been carried out. The area manager told us this would be completed as quickly as possible.

A system for the management of accidents and incidents was not in place. Accidents had been recorded, but there was no analysis of individual accidents and incidents, and no analysis of this information to look for trends and themes. This meant there was a risk that staff would not learn from these incidents and measures may not be put in place to reduce the risk of similar events from occurring again.

There were no quality assurance and audit processes in place, such as audits of medication, premises and plans of care. Therefore the provider had not identified the issues that we identified during our inspection. For example, there were no plans of care audits undertaken although we found shortfalls with ensuring people's care needs were fully met. This showed us that the provider's quality assurance systems were not robust to ensure risks were identified and quickly rectified.

This was a breach of Regulation 10, of The Health and Social Care Act 2008 Regulated Activities) Regulations 2010.

The home had a registered manager in place, who was relatively new to the role and had been registered since mid 2014. One member of staff told us, "I can go to the manager, if I have any problems. She will listen and try to do something about it."

We saw that 'resident meetings' had been held. These provided an opportunity for people to feedback comments or concerns to the management team. The manager stated that she was planning to increase the frequency of these meetings to give people and their relatives more opportunities to feedback their views on the running of the home.

All the people we spoke with said there was a good atmosphere in the home. From our observations people seemed relaxed and had a good rapport with staff. The staff we spoke with told us they were well supported by the registered manager. They said that they had brought issues to her attention, for example the lack of staff on some shifts. The manager had told them she was speaking to the provider about this issue and hoped to be able to have more staff on shifts where needed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who use services had not been provided with care and support that was planned and delivered to meet their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People had not been assured of receiving a quality service because the registered person did not regularly assess and monitor the quality of the service provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **The registered person did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints.**