Onkar Care Home Limited

Onkar Care Home

Inspection report

15 Portman Street
Leicester
LE4 6NZ
Tel:
Website: www.example.com

Date of inspection visit: 14 and 17 October 2014
Date of publication: 24/02/2015

Ratings

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

Overall summary

This inspection took place on 14 and 17 October 2014 and was unannounced. This service, previously known as Onkar Care Home, was re-registered on 18 June 2014 when the provider became a limited company.

Onkar Care Home Limited provides accommodation and support to up to 14 people under the age of 65. The home specialises in the care of people with learning disabilities, some of whom also have physical disabilities. The home is on three floors and as there is no lift people with physical disabilities are accommodated on the ground floor. There were eight people using the service at the time of our inspection.

The home has a registered manager. This 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. Shortly after our inspection the registered manager left the provider's employment and the Local Authority allocated some of their own staff to run the service.

When we visited we found that although some people said they felt safe in the home, staff had not taken

Summary of findings

appropriate action following a recent allegation of abuse. This occurred while the registered manager was on leave. It was not until a social worker visited the home, and advised staff what to do, that action was taken to protect people.

Satisfactory pre-employment checks had not been carried out for all staff. This meant people were not protected from the risk of unsuitable staff.

Medication was not always being given safely in the home and this may have resulted in one person being given medication unnecessarily. The local authority investigation was underway at the time this report was written.

Poor communication and a lack of understanding of the Mental Capacity Act 2005 meant we could not be sure that staff were acting in people's best interests.

People's plans of care did not always contain the information staff needed to support those whose behaviour might present a risk to themselves or others.

Some people said they liked the food, however people weren't always getting the food they had chosen. Due to a lack of assessments we could not be sure people's nutritional needs were being met.

The provider's complaints procedure did not include all the information people needed to make a complaint. In addition, it was only available in a written format. There was no easy-read, pictorial, or otherwise user-friendly version. This made it difficult for some people to understand.

Prior to our visits the registered manager had been on leave. Records showed the provider's safeguarding and notifications policies and procedures had not been followed during this time, and people had been put at risk because of this. In addition the system for assessing and monitoring the quality of the service was not always effective and people had been put at risk because of this.

The staff were caring and got on well with the people they supported. They knew their likes, dislikes, hobbies and interests. People told us that they trusted the staff and approached them if they needed reassurance.

Since the home was re-registered staffing numbers had been increased and this had led to an increase in activities and trips out for the people who used the service.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and a breach of the Regulation 18 (1) (2) (e) (f) of the Care Quality Commission (Registration) Regulations 2009. 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?
The service was not safe.

People were not being protected from the risk of abuse. Staff did not respond appropriately when abuse was alleged to have occurred.

Satisfactory pre-employment checks had not been carried out for all staff so people were not protected from the risk of unsuitable staff.

People were not protected against the risks associated with the unsafe use and management of medicines.

Inadequate

Is the service effective?
The service was not effective.

Due to poor communication and a lack of understanding of the Mental Capacity Act 2005 we could not be sure that staff were acting in people's best interests.

People were not being given a choice of suitable and nutritious food and a lack of records meant it was not clear whether their nutritional requirements were being met.

Staff took appropriate action if there were concerns about the health of any of the people who used the service.

Inadequate

Is the service caring?
The service was caring.

People told us that staff treated them well and we observed warm and caring interactions between staff and the people using the service

Staff were knowledgeable about people's likes, dislikes, hobbies and interests. They were able to tell us about people's daily routines and how they liked their support provided.

People's privacy and dignity was respected and their bedrooms personalised.

Good

Is the service responsive?
The service was not responsive.

People were not having their needs appropriately assessed and the care related to these needs properly planned and delivered. This meant that behaviour that challenged was not being safely managed.

The provider's complaints procedure was only available in a written format so was not accessible to all the people who used the service.

Inadequate

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

The provider had not ensured that suitable leadership or management cover was in place in the registered manager's absence.

Whilst the registered manager was on leave the provider's safeguarding and notifications policies and procedures were not been followed and people were put at risk because of this.

Actions had not always been taken by the provider in response to suggestions put forward by people who used the service.

The registered manager was experienced and suitably qualified for her role and the people who used the service, relatives, and staff had confidence in her. However this person left their employment at the home shortly after our inspection.

Onkar Care 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 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 14 and 17 October 2014 and was unannounced. The inspection team consisted of three inspectors. Before the inspection we reviewed the information we held about the service including notifications. Notifications are changes, events or incidents that the provider must inform us about. We also contacted the local authority about this service. They raised concerns about care, staffing, nutrition, and leadership at the service.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing support in the lounge and dining room. We spoke with seven of the people who were using the service and two relatives. We also spoke with the provider, registered manager, two senior care workers, and four care workers.

We looked at four people's care records, incident reports, medication records, menus, and policies and procedures. We also looked at four staff recruitment records, duty rosters, and the provider's statement of purpose. This is a document which includes a standard required set of information about a service.

Inadequate

Is the service safe?

Our findings

Prior to our inspection it was alleged that an incident of abuse had occurred at the home. When we visited we talked to the registered manager and staff and looked at records to see how this had been managed.

We found that staff had referred the alleged incident to the local authority on the day it happened. However they had not taken action to protect the people who used the service following this incident. Records showed staff had not risk assessed the situation or the people involved. Nor had they taken any other action to ensure people were protected, for example, by increasing staff observations.

It was not until a local authority social worker came to the home, two days after the alleged incident, that any action was taken to protect people. On the advice of the social worker staff agreed to carry out 30 minutes observations on one person in order to protect them and the other people who used the service. These events occurred while the registered manager was on leave. When she returned to the home she took action to address the situation. This included carrying out a written risk assessment of one person to help ensure the people who used the service were safe.

This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at recruitment records and found that inadequate checks had been completed. For example, the provider had accepted undated 'testimonials' instead of references for three staff members. In addition not all staff files contained the required photograph as proof of identity of the staff members in question.

Employing staff without satisfactory pre-employment checks could put the people who used the service at risk of being cared for by unsuitable staff.

This was a breach of Regulation 21(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we visited some staff expressed concerns that one of the people who used the service had been 'over-medicated' while the registered manager was on leave.

We checked this person's records and saw they were prescribed a PRN medication (a medication that is taken 'as needed') for 'agitation'. There was a PRN protocol for this written by the person's medical consultant. This instructed staff to try behavioural forms of intervention before resorting to the use of medication. However records indicated that no behavioural interventions had been attempted prior to the medication being administered.

Records also showed that while the registered manager was on leave the use of this medication had escalated. For example, over a seven day period the medication had been given every day except one, and twice on one day. Prior to this records showed PRN medication was, on average, given twice a week.

We checked the MARS (medication administration record sheets) for this seven day period. They showed that staff administering the medication had written the person was 'agitated' each time this medication was given.

We checked this person's daily records for the same period. These contradicted what was written on the MARS about the person being 'agitated'. They showed that over the same seven day period the person was only recorded as being what could be described as agitated on two occasions. For the rest of the time they were repeatedly described as being 'fine' and staff having 'no concerns' about them.

This demonstrated that staff had not always followed the person's PRN protocol and as a result the person may have been given medication unnecessarily. This may have constituted abuse and we referred this to the local authority as a potential safeguarding issue. A Local Authority investigation in to this was underway at the time of writing this report.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service effective?

Our findings

During our visits we found, or were made aware of, examples of poor communication amongst the staff team, and between staff and the people who used the service.

Some staff told us the quality of 'handovers' of information between staff shared between shifts depended on which staff members were involved. They told us that important information was not always passed on from the previous staff team. The registered manager reported that information about an incident concerning one of the people who used the service was not passed on to her, and she did not find out about it until a social worker contacted her to discuss the incident.

Some staff told us that other staff and the provider talked to each other in a particular language in front of people who used the service and staff who did not understand this language. They told us this also happened in staff meetings. They said this made them feel uncomfortable and anxious as they did not know what was being talked about.

These examples of poor communication showed that some staff did not have the communication skills they needed to carry out their roles and responsibilities. We discussed this with the registered manager who said she was aware of this problem and would be addressing it formally in supervision and training sessions with the staff in question.

We looked at staff training. Records showed that newly appointed staff had an induction on commencing work at the home. However there was little evidence of ongoing training. The registered manager explained that at the time of registration an agency was engaged to provide staff with the training they needed to work in the home. Although this training commenced, and was mostly completed, the agency went into liquidation. The registered manager said that as a result staff did not receive certificates confirming they had done the training.

The registered manager told us that a new programme of training had been booked with a different agency but had not yet commenced, therefore not all training was up to date.

This was a breach of Regulation 23 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

We looked at how staff at the home were following the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA is a law about making decisions and what to do if people cannot make some decisions for themselves due to a lack of capacity. DoLS are part of the Act. They aim to make sure that people receiving care are looked after in a way that does not unnecessarily restrict them or deprive them of their freedom.

We looked at how consent to care and treatment was sought in line with this legislation. The plans of care we sampled showed that people had signed their agreement with them, and/or a relative had signed for them. People had some basic mental capacity assessments in place. For example, '[Person's name] can make daily choices such as what they want to eat and drink, or if they want to go out or not' and an acknowledgement they might need a best interest decision 'for bigger choices' such as how to spend their money, although there was no record of such a meeting taking place.

However, following a recent incident in the home, the police had asked the staff to carry out a mental capacity assessment of one of the people involved. There was no evidence of this being done. The staff we spoke with about this, who had been in charge of the home at the time of the incident, said they were unsure how to do this. We reported this to the registered manager who said she would ensure this mental capacity assessment was done as a matter of priority.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Prior to the inspection we received an anonymous concern that there was a lack of food in the home. We checked food stocks and found that although there was sufficient food in the home, it was not always of the type the people who used the service had said they wanted.

Staff and the registered manager told us meals were planned with the people who used the service and a shopping list prepared. They said that that until recently the registered manager had done the shopping in consultation with people using the service who had accompanied them to the shops. However the provider had

Is the service effective?

decided to do the shopping instead and staff and the registered manager said the provider did not always buy what was on the list. This meant staff could not prepare the meals the people who used the service had chosen.

On the day we inspected staff could not provide all the items on the lunchtime and evening menu. They said this was because the shopping they had ordered had not been purchased. Consequently they had to make something else at short notice and could not provide what the people who used the service had chosen in advance.

This showed that although the people who used the service were encouraged to choose the food they wanted this was not always provided due to restrictions on shopping. Staff told us this was a regular occurrence in the home. However two people did tell us they liked the food. One said, "The food is nice here I like it." Another commented, "Sometimes we have takeaways which I like."

We sampled people's plans of care and there were no nutritional assessments in place. This meant that people's nutritional needs had not been formally assessed by the home. One plan stated a person was on a soft diet but it was not clear why this was. There were no risk assessment in place for choking, nor had consideration been given to referring the person to the SALT (speech and language therapy) team who provide support to people with swallowing difficulties. We reported this to the registered manager and when we returned for the second day of our inspection a referral to the SALT team had been made. This will help to ensure the person in question gets expert nutritional support.

When we checked food stocks we found that some items had been opened and stored, but there were no dates on them to indicate when they had been opened. This meant staff would not know if the food was out of date. We reported this to the registered manager who agreed to take action to ensure any food not fit for consumption was disposed on.

This was a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

People had access to a range of health and social care professionals. These included GPs, dentists, CPNs (community psychiatric nurses), chiropodists, consultations, and social workers. During out visit we saw that one person went to the dentist with a member of staff because they needed a check-up.

Records also showed that staff took action when there were concerns about the health of any of the people who used the service. For example, a GP had recently been called out twice for a person who felt unwell. All interactions with health and social care professionals were noted in people's files and plans of care were adjusted as necessary.

Good

Is the service caring?

Our findings

Two people, who were able to share their views verbally, said they were happy at the home and got on well with the staff. One person told us they had their own keys to their bedroom which they liked as it promoted their privacy. We observed staff interacting with some of the people who used the service and providing them with support. Staff communicated with people in a kind and friendly manner

The staff we met we knowledgeable about the people they supported. They knew their likes, dislike, hobbies and interests. They were able to tell us about people's daily routines and how they liked their support provided.

We asked one person if they wanted to speak with us and they said yes, but only if a care worker could be present. This showed that they trusted the staff member and felt reassured by them.

One person became distressed and a care worker responded quickly. They talked with them gently and soon had the person laughing and joking with them. The care worker told us this person sometimes became distressed when they felt left out and the solution was to socialise with them.

Records showed people were encouraged to make choices about their daily lives. During the inspection we observed staff assisting people in making choices about what they would like to drink, going out, and activities. One person was going shopping and staff took time ensuring they wanted to do this and helping them plan their trip. They gave them instructions on what to do if they changed their mind and wanted to come home.

Records showed that activities were part of life in the home. Staff told us people's hobbies and interests were identified through their life histories and in discussion with themselves and their families. People were then encouraged to take part in group and one-to-one activities depending on what they preferred.

On the days we visited some people were at college and others were out shopping or in the home. We saw that staff assisted people who had not gone out to do activities. These included playing board games with staff, watching TV, and listening to music.

One person returned from college and appeared anxious. A care worker noticed this and engaged them in conversation. They discussed the progress this person had made at college and went over some of their achievements. This interaction improved the person's mood and they were noticeably happier and less anxious as a result.

The provider's policies, procedures and training gave staff guidance on how to respect people's privacy and dignity and provide care that met their needs. These were followed during our visit. Staff were discreet when they provided personal support and assisted people at mealtimes. People's bedrooms were respected as their own space and the décor and furnishings reflected their individual tastes and interests.

Inadequate

Is the service responsive?

Our findings

One person, identified at the inspection, had particular needs that were not being addressed. This lack of action may have failed to prevent several serious incidents that had taken place in the home. We discussed this with the registered manager. She told us staff had liaised with the people and agencies who worked with this person and one agency had referred them for specialist support.

None of this information was documented in this person's plan or care and not all staff were aware of it. For example, daily care notes, completed by senior care workers, recorded that this person had had altercations with another person who used the service. However there was no analysis of why this may have happened, nor any support plan showing an understanding of what might be the root cause of this person's behaviour or how to address it

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We talked with staff about how they responded to people's needs including those who were unable to communicate verbally. Staff told us they referred to plans of care and what they knew about the person from working with them. We observed one care worker supporting a person with limited verbal communication. We saw they had a good understanding of this person's needs and were able to help them choose a TV programme to watch.

Another care worker helped a person choose a meal, reminding them of their cultural preferences with regard to certain menu items. One care worker told us, "All our residents can make it clear what they want and what they don't want. If they can't tell us in words we watch their body language and facial expressions."

No formal complaints had been made directly to the home since it was registered. We received one complaint about the food which we took into account during our inspection. The provider's complaints procedure stated that complaints should be 'sent' to the registered manager. This did not take into account that some people might not be able to produce a written letter of complaint. Nor did it signpost people to advocates or others who might be able to help them make a complaint.

The procedure went on to say that if the complainant was not satisfied with the response they could escalate the complaint to the provider. However it did not state that complaints could also be sent to the local authority, or that we could be informed of them. This meant that people were not given the information necessary to raise complaints externally.

In addition the complaint procedure was only available in a written format. There was no easy-read, pictorial, or otherwise user-friendly version. This meant that some people might have difficulty understanding the complaint procedure.

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

Inadequate

Is the service well-led?

Our findings

Prior to our visits the registered manager had been on leave for two weeks during which time senior carers had been put in charge of the home. During the registered manager's absence an allegation of abuse resulting in a police incident occurred at the home. The provider's safeguarding policy had not been followed and people had been put at risk because of this. Action to protect the people who used the service following this incident had not been taken. Records showed staff had not risk assessed the situation or the people involved. Nor had they taken any other action to ensure people were protected, for example, by increasing staff observations. The provider had not ensured that suitable leadership or management cover was in place in the registered manager's absence.

Staff and a relative told us they were frustrated that promised improvements to the premises had not happened. They said that at a 'residents and relatives' meeting following the home's registration in July 2014 they had been told the premises would be decorated and new furniture purchased for the home. This had not yet happened.

Staff told us they had tried to improve the premises themselves using their own time and resources. One staff member said they had sourced free paint and suggested they redecorate the home in conjunction with the people who used the service. They had also offered to tidy and improve the patio area outside of the home. However they said these suggestions had not been taken up by the provider.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

During the registered manager's absence an allegation of abuse resulting in a police incident occurred at the home. The provider was aware of this but did not report it to us. As the registered person the provider had a duty to notify us of such an incident without delay.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager, who had been in post for six months, had substantial experience in the care sector and was suitably qualified for her role. Two people who used the service told us they liked and trusted the registered manager. One person said, "If I'm worried about anything I can talk to the manager." Staff and a relative told us that both they and the people who used the service got a sense of safety from her presence in the home. One staff member told us, "Before the manager came the residents were all anxious – now they are calm and settled."

The registered manager told us she varied her working hours so she was able to support both day and night staff and was on call when not at the home. The registered manager and staff consulted with the people who used the service about the way the home was run. They had monthly meetings to discuss menus, activities, and other aspects of the home. Record showed these meetings were well attended.

Through listening to people's views some changes had been made at the home. For example, people had requested a cooked Sunday breakfast and a Sunday roast dinner and this had been provided. People had also asked for trips to the cinema, disco and gym and these had been organised for them.

Following the inspection we were informed by the local authority that the registered manager had resigned her post and left the home on 30 October 2014. Due to the local authority's concerns about the safety of the people in the home they immediately sent some of their own staff there to run it.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People were not being safeguarded from the risk of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not being protected against the risks associated with the unsafe use and management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person was not operating an effective recruitment procedure.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Staff were not delivering care and treatment to the people who used the service safely and to an appropriate standard.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Action we have told the provider to take

	The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not being given a choice of suitable and nutritious food and a lack of records meant it was not clear whether their nutritional requirements were being met.

Regulated activity	Regulation
	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person was not notifying us of specific incidents in the home as required.

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 provision The registered person was not was not protecting the people who used the service from inappropriate or unsafe care and treatment.