Malhotra Care Homes Limited

Covent House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Covent House commenced on 1 August 2017 and was unannounced. A second day of inspection took place on 2 August 2017 which was announced.

The inspection was prompted in part by a historical notification of an incident following which a service user may have sustained a serious injury. During the inspection the Commission became aware of a further incident were a service user died. As such a third day of inspection took place on 5 September 2017 to ensure the immediate safety of service users. These incidents are subject to criminal investigation and as a result this inspection did not examine the circumstances of the incidents.

However, the information shared with CQC about the incidents indicated potential concerns about the management of safeguarding concerns and medicines. This inspection examined those risks.

We last inspected Covent House on 17 June 2015 and found it was meeting all legal requirements we inspected against. We rated Covent House good in all domains at that time.

Covent House is registered to provide accommodation for up to 63 people who need nursing and personal care. It provides a service primarily for older people, including people living with a dementia related condition.

At the time of the inspection there were 57 people using the service.

The service did not have a registered manager. The current manager had been in post for five weeks prior to the inspection and had submitted an application to the Commission to be registered. The previously registered manager had left their post on 29 July 2013 but had failed to cancel their registration. Managers had been in post during this time but had not registered with the Commission.

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.

During the inspection we found areas of concern which constitute breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely safe care and treatment, safeguarding service users from abuse and improper treatment, the need for consent and good governance.

Medicines were not always managed safely for people and records had not been completed correctly.

A recent safeguarding incident had identified failings in relation to risk management, communication, documentation and training. Improvements were being implemented at the time of the inspection.

People were not consistently supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. This meant there was a failure to follow the principles of the Mental Capacity Act (2005) in relation to mental capacity assessments and best interest decisions.

Accurate, complete and contemporaneous records in respect of each person's care and support had not always been maintained.

The provider's quality assurance systems had not identified the concerns in relation mental capacity assessments, best interest decisions and some care documentation.

We have made a recommendation about the planning and assessment of care.

Complaints were investigated and there was a record that complainants were satisfied with the outcomes and action taken. The management of one complaint, with regard to a specific safeguarding incident, was being investigated.

The manager completed weekly audits, in addition to walk around checks and audits of medicines, the dining experience and care records. The head of compliance also completed an audit. An action plan was in place which had resulted in some improvements.

The manager had a strong leadership style with a positive vision for the future of Covent House. Staff were complimentary of their approach and felt improvements had been made.

Recognised risk assessment tools were used to assess risks such as pressure damage and nutritional risks. Other risks such as mobility and falls were assessed. Areas of concern were included within care plans.

Some care plans were detailed and provided staff with specific strategies to follow to ensure people received appropriate and consistent care and support, others were not.

People nutritional and health needs were met and we saw referrals had been made to healthcare professionals.

Staff told us there were enough staff to meet people's needs. We observed staff were not rushed and were able to spend time engaging with people in a meaningful and respectful manner. If people had been funded for one to one support we observed this was being provided.

People and staff were observed to have warm relationships with each other. Everyone we spoke with was complimentary about the care provided and the approach of the staff.

A range of activities were offered, including a cinema room, a gentleman's club, outings, community involvement, entertainers, music therapy and pet therapy.

There was a reliance on agency staff. Safe practices were followed to ensure agency staff had the required skills to meet people's needs. A recruitment campaign was underway and safe systems were being used to ensure only appropriate staff were employed.

Staff said they felt well trained and well supported. The provider had identified some improvements were required with regards to supervision and training and this was being addressed.

You can see what action we told the provider to take at the back of the full version of the report

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely for people and records had not been completed correctly.

Areas for improvement had been identified following recent safeguarding incidents and actions to improve processes were being implemented.

Some risks were assessed and management plans were in place to minimise risk in relation to specific areas such as moving and handling, skin integrity and nutritional risks. For other risks there was a failure to ensure documentation was in place and up to date.

A recruitment drive was in place due to the level of agency staff being used, however staffing levels were maintained at the level identified by the dependency tool.

Safe systems were in place for the use of agency staff, and the recruitment of new permanent staff.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act (2005) were not being followed in relation to mental capacity assessments and best interest decisions.

Staff said they felt well supported and well trained although we found some training was out of date. The provider had identified improvements were needed in relation to the regularity of supervision meetings with staff, the completion of annual appraisals and some training.

People were supported with their nutritional needs and we saw appropriate referrals to health care professionals such as community matrons, social workers and chiropodists.

Is the service caring?

Good

The service was caring.

People and visitors spoke highly of the care and support they received from staff.

We observed warm, respectful and compassionate relationships between people and staff.

People told us they were involved in day to day decision making, and relatives confirmed they had been involved in care planning.

A variety of information was available for people including safeguarding, complaints and advocacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans did not include the information needed to ensure safe care and treatment was provided, however staff knew how to support people and how to keep them safe. Other care plans were detailed and included specific strategies for supporting people. We have made a recommendation about care planning.

A range of activities were provided and the activities coordinators were very engaged with people.

Complaints were recorded and investigated. The management of one previous complaint was currently being investigated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems had identified some areas for improvement and an action plan had been implemented however some actions had not been completed and some concerns had not been identified.

Staff told us they thought Covent House was well-led and they acknowledged the new manager was making improvements.

The manager was respected by the staff team and had a strong vision for the future of Covent House.

Covent House

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 1 August 2017 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 2 August 2017 and was announced. A third day of inspection took place on 5 September 2017.

The inspection team was made up of two adult social care inspectors', a specialist professional advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 5 September the inspection was completed by a CQC pharmacist specialist and focussed on how medicines were managed in the service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider was in the process of completing a Provider Information Return (PIR) during the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We also contacted the local authority commissioning team and the safeguarding adult's team.

During the inspection we spoke with six people living at the service and three visitors, two of whom were people's relatives. We also spoke with the manager, three care assistants, two activities coordinators, one team leader, a nursing assistant practitioner and three nurses, one of whom was an agency nurse. We spoke with ancillary staff including a housekeeper, chef and kitchen assistant. In addition we spoke with the operational support manager, head of compliance, head of care and the nominated individual.

We reviewed six people's care records and five staff files including recruitment, supervision and training information. We reviewed medicine records for eight people, as well as records relating to the management

of the service. On the third day of inspection we looked at the arrangements for the management of medicines. We spoke to five members of staff and one relative. We also looked at medicine records and care plans for 11 people.

We looked around the building and spent time in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were handled and found that the arrangements were not always safe.

The provider was currently using an electronic medicine system but had identified shortfalls in the system that they felt made the service less safe. They planned to move back to a paper based medicine administration records (MAR) in October 2017. In the interim period to manage the risk, the provider had put in place systems to address some of the current issues. These included discussions with the pharmacist and the providers of the electronic MAR system in order to ascertain appropriate ways to manage the issues. This included the use of medicine discrepancy sheets to help prevent people running out of medicines and using paper copies of the MARs when agency nurses were working in the home. However, despite these additional systems, we found records relating to medicines were not completed correctly placing people at risk of medicines errors.

We found a number of gaps in administration records where nurses, mainly agency staff, had not signed either the paper records or in the electronic medicine record. We also saw when people had not taken their medicines, for example if they refused or did not require them; the reason for not giving the medicine was not always clearly recorded. This meant administration records did not provide a clear picture of all medicines a person had taken or not.

Several people were prescribed creams and ointments. Care staff applied many of these as part of personal care or when people first got up or went to bed. There were records, including a body map that described for care staff where and how often these preparations should be applied. However; for some creams, there was no guidance in place and some records were not fully completed. We also saw that some records showed creams were not applied at the frequency prescribed. These records help to ensure that people's prescribed creams and ointments were used appropriately.

We found the individual guidance, to inform staff about medicines prescribed to be given only when needed, was not always available. Information was not person centred or had not been updated when a medicine was changed. For example, one person was prescribed a medicine for anxiety and the dose on the MAR was unclear. Staff had identified this on the MAR with a 'post it note' querying the dose. However no one had followed the query up with the prescriber and there was no care plan or further information in place. For another person, prescribed when required medicines for constipation, the information in the care plan was not person centred and the dose in the care plan was different to the dose on the MAR. This information would help to ensure that people were given their medicines in a safe, consistent and appropriate way.

Some people had medicines administered covertly. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. We saw that the GP had authorised covert administration (adding medicines to food) for people who did not have capacity and were refusing essential medicines. The pharmacist had also given guidance on whether medicines could be crushed and added to food. However, two people had one medicine each that was not listed on the GP authorisation. In addition,

information on how this would be done was not clear. For example, one person's record said that medicines would be crushed but we were told they were administered whole in food. For other people the nurse told us covert administration would only be used if the person refused their medicines but this was not documented in the guidance on how people took their medicine. This information is necessary to ensure people were given their medicines safely and consistently when they were unable to give consent.

For medicines that staff administered as a patch, a system was in place for recording the site of application; however, they were not fully completed for two people whose records we looked at. For another person who was prescribed a medicated patch for the treatment of Parkinson's disease, there were incomplete records in place to show where the patch was applied and the application site was not rotated in line with the manufacturer's guidance to prevent side effects.

One person had been assessed as presenting with some behaviour which was challenging to staff, including expressions of suicidal ideation and self-injurious behaviour. There was no risk assessment in place to support staff to manage and mitigate the risk of harm. There was a note to say the behaviour team were involved and staff confirmed they were involved however there was no written guidance for staff to follow.

The failure to review and update risk assessments following specific incidents meant there was a failure to assess and mitigate risks of incidents happening again.

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

We looked at the procedures to safeguard people from harm and abuse. A safeguarding file was in place and we saw safeguarding concerns were reported to the relevant agencies. We found some records were not stored in the safeguarding file, however through discussion with the management team of Covent House it was apparent that the records had been removed due to an ongoing internal investigation relating to a specific incident.

Local authority safeguarding procedures had identified several failings in relation to keeping people safe at Covent House. Including a failure to review and update risk assessments following specific incidents; a failure to report incidents in a factual and timely manner and a failure to seek medical support in a timely manner. There were additional concerns in relation to communication and training. Actions to address these concerns were being implemented at the time of the inspection so we were unable to assess improvements.

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

Minutes of health and safety meetings confirmed safeguarding concerns were discussed, as were accidents and incidents. It was noted as an action in the February 2017 minutes that family members should be informed of incidents and concerns as soon as possible.

People and their visitors told us they felt safe at Covent House. One person said, "Staff are very, very good, they look after you well." Another person said, "I would say that I feel very safe here but I can't put into words why." A third told us, "It's all okay here, we're all safe and well looked after." A fourth person said, "Oh, I'm quite safe here, the care and attention couldn't be better." People told us they received their medicines regularly. One person said, "I take a few tablets but I get them regularly and staff wait until I've taken them before they go." We observed two medicine rounds. The nurses followed safe practices and treated people

respectfully.

Medicines were stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medicine. Some prescription medicines are controlled under the Misuse of Drugs because they are liable to misuse. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered. Stocks of these medicines were audited weekly. Eye drops, which have a short shelf life once, open were marked with the date of opening. This meant the home could confirm they were safe to use.

A staff member said, "If I saw or thought anything abusive was happening I would report it, I'm sure it would be acted upon, the manager would support it." Another staff member told us, "I am happy with the staff, people get the right care and no one is treated badly."

The care planning process included identifying 'areas of concern.' These related to the management of risk and care plans contained some information on how to minimise risk. For other areas risk assessments were completed which included an assessment of the level of risk and action to take to mitigate risks to the health, safety and welfare of people. Risk assessments were completed for moving and handling, mobility, falls, nutrition and hydration, continence and skin integrity. A staff member said, "The nurses do the moving and handling plans or the physiotherapist." Assessments had been completed to identify which people were at risk of developing pressure ulcers and preventative pressure relieving measures were in place for those people who required them. The provider used recognised risk assessment tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) to complete individual risk assessments, which helped identify the level of risk and appropriate preventative measures.

Health and safety checks of equipment and the premises were completed, including gas and electrical safety. Checks were completed on hoists, bed rails, window restrictors and fire safety. The staff we spoke with understood the action to take in the event of a fire alarm sounding. A staff member said, "We do a scenario and get to do a pretend evacuation, it's a role play of where you would go (evacuate)." Personal emergency evacuation plans (PEEPs) were completed for each person. We noted one had recently been changed from an assessment of medium risk to high risk. Staff explained this was due to a change in the person's presentation as staff had noted the person could be quite anxious with strangers.

People and visitors we spoke with told us they thought there were enough staff to meet people's needs. One relative said, "There could be more staff but there could always be more staff, things seem to have got better over the past month." We observed staff were able to spend time with people and were not rushed. People funded for one to one care were observed to be receiving this and nurse call bells were responded to in a timely manner.

One nurse said, "Staffing is really good, always fully staffed." Another staff member said, "The manager is recruiting new staff, we have a lot of agency staff at the minute." They added, "I would like some permanent staff, some continuity of staff on the dementia floor." Another staff member said, "Lots of staff have left so there's lots of agency, we always say if they are bad and they don't come back. I would prefer some consistency." A third staff member said, "Yes, there's enough, we don't struggle." Another staff member said, "I always work on the fourth floor, I know people well, what makes them agitated and what makes them happy, it makes the day better if people are happy."

Dependency assessments were completed which ensured there was a summary of the care needs of each person. This was used to generate a staffing level to ensure an appropriate number of staff were available to meet people's needs. The head of operations said, "The dependency tool gives a general guide and includes

nursing staff but any one to one support is added over and above the dependency tool." Rotas reflected the required staffing levels and we saw that one to one support was provided in addition to the dependency tool.

The manager explained there was an ongoing recruitment campaign in place and new staff were being appointed. The staff shortages were attributable to staff turnover and other reasons that the provider had responded to as appropriate. Where agency staff were used, the manager tried to ensure the same staff were used to provide consistency for people. Agency profiles were sought to ensure staff had the appropriate training and checks in place before they supported people.

Recruitment processes included an application form and interview. If successful at this stage a minimum of two references were sought and verified as well as the receipt of a Disclosure and Barring Service check (DBS). DBS checks are used to enable employers to identify people with a criminal record and make appropriate decisions to ensure only suitable people are employed to work with vulnerable adults and children. DBS checks were renewed on a three yearly basis and Nursing and Midwifery Council checks (NMC) of nurse PIN numbers were completed monthly. The nominated individual told us the provider was developing their own bank staff which would reduce the reliance on agency staff to cover staff absence.

People and visitors told us they thought Covent House was clean and well maintained. We found this to be the case during our inspection. One relative said, "They come in every day and clean the room and the bathroom." A member of housekeeping told us, "All the resources are in place. We have resident of the day so one room is deep cleaned every day."

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

For people who did not always have capacity, mental capacity assessments and best interest decisions had been completed however we found inconsistencies in recording. Some decisions were not specific, for example, 'consent to stay at Covent House and receive treatment and care for general health and wellbeing (this includes medication).' The MCA says a person's capacity must be assessed specifically in terms of their capacity to make a particular decision. We found this was not always the case. Records of best interest decisions showed involvement from two nurses who worked at Covent House but no one else. This meant people's rights to make particular decisions may not have been upheld and their freedom to make decisions may not have been maximised.

One person had a capacity assessment and best interest decision in relation to an intimate relationship. The Mental Capacity Act Code of Practice states, 'Decisions concerning family relationships (Section 27). Nothing in the Act permits a decision to be made on someone else's behalf on any of the following matters:- consenting to have sexual relationships.' This meant there was a failure to the follow the principles of the Mental Capacity Act (2005).

These concerns are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A staff member spoke with us about mental capacity. They said it was about, "People's ability to make decisions, it's about informing people about risks and supporting consideration and follow through to make a decision. It's done in a safe way and we shouldn't be overruling people. It's about their level of understanding, it underpins everything."

We spoke with staff about the support and training they received. One staff member said, "I feel trained and supported to meet people's needs. Sometimes people can (be distressed) during personal care but that's understandable. We always explain what we are doing but some people might not understand." Another staff member said, "Supervision is every eight weeks, we can discuss grievances, anything we could add to

make the home better, staffing, if I or the manager had issues, safeguarding, whistleblowing, social media policy (is discussed)." They added, "Appraisal is once a year, the manager did mine, we discuss time keeping, how I am doing in the job, any concerns, we had to score ourselves, training (is also discussed)." One nurse said, "I can discuss if there's anything wrong, medication supervisions are yearly, manager does them, I can have meetings if I want with the manager." They added, "Appraisals are yearly, the manager does them, it's to discuss job knowledge, how we are getting on with colleagues, medication, things they have noticed (about performance)."

A supervision and appraisal matrix was in place and it was noted there were inconsistencies in the regularity of supervisions. This had been identified within the provider's quality assurance systems and action was being taken to ensure supervision was planned in line with the providers policy and that annual appraisals took place.

One staff member said, "I did an induction, it was over three days but I also completed the care certificate and was involved in shadowing while I completed my care certificate. I've done lots of training, safeguarding, moving and handling, fire safety, mental capacity and DoLS." They added, "Training is excellent, I couldn't physically do anymore. I had a probation meeting at six months in post. The manager who did my induction did monthly sit downs with me to go through everything, performance, support and things."

A nurse said they had attended, "Moving and handling, safeguarding of vulnerable adults, food hygiene, all face to face training, and catheterisation and syringe driver." A staff member said, "All my training is up to date, I'm due moving and handling and documentation top up courses, I've done nutrition and medication competency." Another staff member said, "We have yearly training, we always do it before it runs out. I've done dementia training, challenging behaviour, communication, mental capacity and deprivation of liberty. The manager used to do all the capacity assessments but we are getting involved now." Another staff member said, "I've had dementia training and been to dementia sessions. I've done Non-Abusive Psychological and Physical Intervention (NAPPI) training but I haven't had to use it." They added, "I've also done safeguarding, health and safety, food hygiene, level 2 and level 3 in health and social care, dignity." Another staff member said, "If I wanted to do any additional training I could go to (manager), they are supportive and approachable."

A Nursing Assistant Practitioner (NAP) was employed. They had attended additional training and competency assessments in order for them to undertake a more specialised role. The manager explained that within Covent House their role was to administer medicines, they did not engage in any invasive treatment as this would always be completed by a member of the nursing team.

A training matrix showed that not all staff had attended training in dementia care, challenging behaviour, mental capacity or deprivations of liberty safeguards. It was also noted that not all nursing staff had had their clinical competency assessed in relation to pressure ulcers, tissue viability, nutrition and hydration or catheter care. Training had been identified within the providers own quality assurance systems as an area requiring action.

Systems were in place to ensure people who were identified as being at risk of poor nutrition were supported to maintain their nutritional needs. This included referrals to dieticians and the speech and language therapy team. There was also specific information in relation to fortified diets, and specialist diets such as for a person with coeliac disease and another person with cultural needs relating to their diet. The chef told us they had lots of information on specialised diets that people needed or chose due to personal dietary preferences. They said, "We have all the information we need on each person's needs, it's all

recorded. The head chef had received training on using molds for people who need a pureed diet. People's appetites have improved dramatically since we've been using the molds."

Malnutrition Universal Screening Tool (MUST) was used to complete individual risk assessments to relation to assessing the risk of malnutrition and dehydration. This helped identify the level of risk and appropriate preventative measures. Staff monitored some people's food and fluid intake and charts were fully completed however intake goals were not recorded, which meant staff may not have been effectively monitoring people's intake and taking action, as required.

People told us they enjoyed the meals. One person said, "Lunch was really nice, I enjoyed it." Another person told us, "The food is alright, there's plenty of it and there's always sandwiches if you don't like the meals or you're not feeling hungry." A relative said, "We bring in some traditional food for [person], they don't mind, we just bring it once or twice a week because it has spices that [person] enjoys." Staff confirmed that if people wanted something different to eat, if the kitchen was told it could be provided. We noted there was differing information on display about the menus and what people were actually served. Folders were available with a range of pictures of meals which staff could use to support people to make decisions about their meal chooses however there was no pictorial menu on display.

During meal times people were offered a range of hot and cold drinks. If people required support with their meal this was provided in a sensitive manner with encouragement and praise being offered alongside appropriate conversations. On one occasion we observed staff reminiscing with a person about television adverts and they started to sing a song which the other diners joined in with. Staff were attentive to people's needs asking if they would like some more to eat or a drink.

The chef explained that two people who had a diagnosed learning disability had jobs in the kitchen. Their placements had started through a local authority scheme to find and maintain employment for people. The head of operations confirmed that both people were, "On the payroll." One kitchen assistant told us, "I enjoy it, I'm very busy, I do the sandwiches and the dishes."

People's care records showed details of appointments with, and visits by, health and social care professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. For example, General Practitioners (GPs), Psychiatrists, Community Matrons, community nurses, social workers and chiropodists. Care plans reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with various healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met.

Good

Is the service caring?

Our findings

During the last inspection the service was rated good in this domain. We found this rating had been sustained. We observed staff knew people well and there was a good rapport between staff and residents. There was a warm, homely atmosphere and people looked relaxed in their surroundings.

All the people and visitors we spoke with were positive about the care provided at Covent House. One person said, "I couldn't wish for better, they're like Florence Nightingale and Mother Theresa but better because they're here and now and not in the history books. I'm settled here and quite happy here and the staff are a credit to themselves, their job and the home." They added, "Everyone is very kind, very caring, you just need to ask staff if there's anything you want and they will help you. Everything is very satisfactory but if there was anything you would just ask and they would sort it." Another person told us, "I like it here very much, the meals are good, the bed is good and the girls are good. " They went on to say, "If you need anything the girls will get it for you, like if I want some sweeties they will get them when they go out."

One relative said, "[Person] likes [staff member] so we mentioned this to the staff and [staff member] always cares for [person] when he's on duty." Another relative said, "[Person] and [person] are quite settled here and I've got no concerns. They all look after them very well." A visitor said, "I've been coming here for the past five years to visits friends and former neighbours and I've found everything to be okay. I've got no concerns. I'm made to feel welcome and I can come when I want and stay as long as I want and they always make me a cuppa."

One person said, "Staff are very good, very friendly and they talk to you. If I can't do it for myself they will help you to do it or do it for you." Another person said, "It's alright here, I've nothing to complain about." Another person told us, "I couldn't be happier here."

A staff member said, "The best thing is putting a smile on someone's face, it's hard for family and friends and knowing I can make a difference makes it all worthwhile." A nurse told us, "Residents are well looked after, most families are happy about how residents are looked after." A staff member said, "I love the resident's, love the home, we've got some brilliant care staff, I love my job, I never switch off." Another staff member told us, "I love it, I love my job, I always work on the EMI nursing (elderly mentally infirm) unit, I love it." Another staff member said, "The atmosphere is lovely, I love spending time with residents, the activities are good, films, singing, pet therapy."

We observed staff knew each person by name and supported people in a kind way, treating people with dignity and respect. Conversations were relaxed and pleasant with an element of shared mutual laughter and fun.

Staff supported people with moving from their wheelchair to a comfortable chair to make sure they were not spending long periods of time seated in wheelchairs. Staff asked people if this was what they wanted and explained to the person what was happening and what they needed to do, offering guidance and reassurance, whilst maintaining the person's dignity.

None of the people we spoke with could recall signing any care plans but they were all positive about the care and support provided at Covent House. The relatives we spoke with confirmed they had been involved. One relative said, "[Person] and [person] were in another home before they came here but [person] needed more support so they came here. The plan was put together and everything's turned out okay. They've both settled in."

Care documentation included Emergency Health Care Plans and end of life care plans. This meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

Care records included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which had been appropriately completed. These were up to date, the correct form had been used and included an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

People told us they were involved in day to day decision making and were able to choose what time to get up and go to bed, how and where they had their meals, when they had a bath or shower and how they chose to spend their day.

A monthly newsletter was produced which included people's birthdays and welcomes to new people. There was a list of events for the month, including outings, entertainers, dates and prices for the hairdressers visits and information on the chiropodist's pricing. There was also information on historical events that had happened that month in history, such as the battle of the Armada and the opening of the Panama Canal.

Dates of residents and relatives meetings were displayed around Covent House, although the activities coordinators explained that attendance was low. They were looking at ways to improve this.

There were notice boards on each floor containing information about visiting health professionals, how to make a complaint, safeguarding information, activities, church services and menus. A service guide included information on advocacy services and people would be supported to access this information if needed. Advocacy is a process of supporting and enabling people to express their views and concerns, explore choice, access information and promote rights and responsibilities.

Information on forthcoming residents and relatives meetings were displayed in the lifts and there was an August edition of the Covent House Newsletter available in lounge areas and a coffee shop area on the ground floor.

Requires Improvement

Is the service responsive?

Our findings

We reviewed peoples' care documentation and found the level of detail varied. Care plans in relation to behaviours which may challenge staff stated staff should use 'diversional techniques' however there was no detail about what the techniques were. Staff were able to describe the strategies used, and we observed some strategies being followed by staff however they were not recorded. For one person we found there was no recorded guidance or strategies. There had been involvement with the challenging behaviour team but there were no records within care documentation as to the advice provided. Staff were able to describe the triggers for the person's behaviour and the strategies they used to support the person and they explained why particular strategies were being implemented.

For one person who had expressed ideas of self-injurious behaviour there was a care plan in place which stated their expressions but there was no detail on any action for staff to take should the person discuss these feelings with them. One staff member said, "I ask why (person) is feeling like that and have a chat and give them a job to do." They added, "They then have something to do and feel valued so they feel better." This information was not recorded within the person's care records. Another person was described as presenting with 'unpredictable behaviour' but there were no detailed strategies for staff to follow within the care plan, this information was however included within an 'as and when' required medicine protocol.

Care plans were reviewed monthly, and some were reviewed in line with peoples changing need, however the care plan itself was not always updated. This meant some vital information about changes to need and support were recorded in a review but not transferred to a care plan so the information may have been missed.

We recommend the provider seek advice and guidance from a reputable source in relation to person centred care planning.

Other peoples' care records were detailed. For example, one person's care plan in relation to their behaviour management was personalised and specific. It detailed the exact support staff were to provide, how they should monitor after the incident and who they should contact for additional support if needed. Triggers for the behaviour were well documented so staff could recognise them and offer intervention before the person became increasingly anxious and distressed. There was also information on why the person may be presenting with the behaviour such as pain, being unwell, being over stimulated or having a low mood. Staff were directed to offer support to resolve the problem by offering the person time, using verbal and nonverbal cues to communicate and to show they were listening to the person. This provided guidance to staff so care could be provided in a consistent and positive way. This protected people's dignity and rights.

Other examples included communication care plans which detailed specific information for staff to follow in relation to how they engaged with people. This approach meant staff engaged positively and acknowledged that people living with communication needs could still be engaged in decision making and interaction. A detailed care plan was in place for one person who had a specific medical condition. The care plan included information on the person's history and medical vulnerability. There was also information in relation to

monitoring for symptoms of them becoming unwell and the specific action staff should take.

All the care records we looked at contained a pre-admission assessment of people's needs before they moved into the home. Following this initial assessment, care plans were developed. This was followed by a six week review which involved the person and any appropriate family members.

People's needs in relation to mobility and continence care were assessed and appropriate care plans developed. Records confirmed the level of support people needed to maintain their personal hygiene together with access to the dentist, optician and podiatrist.

Care records contained 'This is Me' documents and social profiles which included details about the person's preferences, interests, people who were significant to them, spiritual beliefs and previous lifestyle. It is important people's personal history is recorded as it enables staff to better respond to the person's needs and enhance their enjoyment of life. This information also supported the provision of activities which met people's needs.

Covent House employed two activities coordinators who said they were both level three qualified carers so could also provide care and support. One activities coordinator said, "We have the best of both worlds, we have a lovely job and get to know everyone." They had attended specific training with Equal Arts and the Care Alliance in relation to meaningful activities for people living with a dementia and had recently won an activities back pack for completing their training. Both activities coordinators were dementia activity champions.

A cinema room was available within Covent House which was used for a range of activities, such as crafts and reminiscence as well as for screening films. A gentleman's club was also held which included a movie afternoon such as comedy screenings, games, chess and a glass of shandy. Other activities included singers, music therapy, the discovery zoo and entertainers. Community involvement was encouraged and local school children visited. Work was in progress to organise a choir with Equal Arts. Equal Arts is a charity working to improve the lives of older people through creativity and arts activities. The local supermarket often donated raffle prizes and we saw they had also dressed up and visited Covent House to support people with baking.

A complaints file contained a log which allowed for an overview of any received complaints or concerns and provided an overview of accountability and progress. Letters were sent to complainants and their satisfaction with the outcome of investigations was noted. We saw the management of one complaint relating to a recent specific incident was currently being investigated due to concerns with how it had been managed. For clarity this concern did not involve the current manager.

None of the people or visitors we spoke with had ever made a complaint but they all confirmed they would speak to the staff or the manager if they had any concerns. Various compliments had been received, including, 'staff are very helpful,' 'carers are excellent.' A visiting music therapist had written, 'Activities coordinators are really inspiring to their clients.'

Requires Improvement

Is the service well-led?

Our findings

The current manager had been in post for five weeks at the beginning of our inspection and had made an application to the Commission to become the registered manager. They had had some involvement with Covent House prior to commencing in post in terms of becoming familiar with systems and processes. Before they came into post the operational support manager had been managing Covent House and they remained involved in supporting the new manager with their induction.

The previously registered manager had not cancelled their registration with the Commission and had left Covent House in 2013. Since then there had been two further managers who had not registered with the Commission. This meant the service had been without a registered manager for over two years. Managerial and leadership instability had impacted upon Covent House and there were clear areas for improvement.

During the inspection we found some areas for improvement had been identified by the provider. The head of compliance had completed an audit in April 2017 which had scored compliance at 54.51%. Following this audit an action plan had been implemented on 28 April 2017 to drive improvement. For example, discussions around appropriate language use and the introduction of daily walk arounds by the manager. The action plan also identified that, 'all residents without capacity to have MCA assessments and were required best interest decisions' and 'all care plans to have information identified in risk assessments and from other professionals.' These actions had not been marked as complete. During the inspection we found concerns in relation to MCA and care documentation had not been addressed, including a failure to effectively assess and mitigate risk. We found documentation did not always provide staff with sufficient detail in relation to how to support people. This meant there was a failure to maintain accurate, complete and contemporaneous records in respect of some people using the service.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. The provider had completed regular medicine audits and identified some issues however these had not identified all of the issues we found.
These concerns had not been identified through the provider's own quality assurance systems.

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

Manager's reports had been completed on a weekly basis. They included updates on recruitment and the use of agency staff. The most recent report noted that two staff had been offered full time posts and recruitment checks were in progress. Updates also included information on safeguarding concerns, complaints, health and safety.

Various other audits such as infection control, dining audits, and care plan audits were completed. There had been a Quality Assessment Framework visit by the local authority in July 2017 which had identified some areas for improvement akin to those identified during our inspection. The manager planned to combine any actions onto one overarching action plan which would be used to drive continuous

improvement.

People who used the service and relatives we spoke with thought Covent House was now well-led. One relative said they had completed a survey about care a few months ago. They also confirmed they were aware of residents and relatives meetings but had chosen not to attend.

We spoke with some staff about their involvement in the running of Covent House. There were differences of opinion on the frequency of staff meetings but staff confirmed they were held. One nurse said, "During flash meetings we can put forward ideas. They (management) are ready to accept ideas. One resident needed a moveable specialist chair and I spoke to the manager. We should be getting the chair this month." Another staff member said, "I can ask to speak to the nurse or manager, we have daily flash meetings." They added, "Staff meetings are monthly, if there's issues the manager would call a staff meeting, discuss sickness, anything new going on in the home, new policies and procedures, introductions to new staff."

In addition, head of department meetings for each floor were held, as well as staff meetings, night staff meetings and nurse meetings. Set agendas were used which included safeguarding, complaints and lessons learnt, care standards, health and safety issues, training and updates on the running of the home. Staff told us meetings were held regularly but they weren't always able to attend due to the times of meetings. They said some nurses held catch up meetings to brief staff on the headlines from meetings, whilst other nurses didn't. Managers meetings were also held were all managers from the Prestwick Care Group came together to discuss lessons learnt and areas for improvement.

One staff member raised during the inspection that they would benefit from additional information on people's specific cultural and religious beliefs. They said, "It's about the complex elements that could be dealt with better if we had more information." We spoke with the manager and head of operations about this and they were enthusiastic about arranging some workshops for staff. They acknowledged the importance of staff being able to make suggestions about areas for improvement and were pleased this had been raised.

The manager completed a daily walk around of the building, at various times of day, looking at people's presentation, the environment and health and safety observations. Information in relation to people who were funded for one to one care was provided and it was noted that this level of support was evident on each walk around.

Everyone we spoke with was complimentary about the management team and the improvements that were being made. A nurse told us, "The manager is lovely, they're new, you can go and tell them anything, they're approachable." Another staff member said, "I like them, they're firm but fair, a lot of people don't like change and some staff have left, you have to give people a chance." Another staff member said, "I like the manager, they give direction and we need a manager like that. They can get things done."

One staff member told us, "It's much better now (manager) has come, they have made a massive difference. Complacency has stopped and they've brought standards back 100%. We need a stable hand at the helm. They are really supportive, we are acknowledged, supported and valued." Another told us, "The manager is supportive and approachable, they come up every morning and evening and thank people which is nice. They are getting to know the residents and the staff, they visit people in their rooms and have a chat." They added, "(Manager) is making improvements." A member of ancillary staff said, "We are very well supported by (manager), we get lots of back up from them. It's nice to hear positive feedback. I have no issues." The nominated individual said of the manager, "They have an exceptional leadership quality."

The manager had a strong vision for the future of Covent House. Gateshead has been awarded vanguard status by NHS England for its work to improve the health of patients living in care homes. The manager explained that Covent House was involved in part of the vanguard falls training programme. The aims of which are to develop policies and training using national guidelines on falls management. The impact, once implemented, is to ensure individualised plans to prevent falls, monitor trends, develop falls management protocols and falls prevention where possible. This may then prevent unnecessary hospital admissions through managing frailty. This meant the new manager had regard to the benefits of ensuring best practice was understood and could be implemented to make future improvements to the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There was a failure to follow the principles of the Mental Capacity Act (2005) in relation to mental capacity assessments and best interest decisions. Regulation 11

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not consistently provided in a safe way. There was a failure to assess, and do all that was reasonably practicable to mitigate the risks to the health and safety of service users of receiving care and treatment. Regulation 12(1), 12(2)(a), 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to protect people from abuse and improper treatment. Regulation 13(1)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA RA Regulations 2014 Good governance

Systems and processes had not been operated effectively to ensure compliance.

There was a failure to ensure accurate, complete and contemporaneous records in respect of each person's care and treatment.

Regulation 17(1), 17(2)(c)