Malhotra Care Homes Limited

Addison Court

Inspection report

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16 June 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 22 October, 6 and 9 November 2015. Three breaches of legal requirements were found relating to safe care and treatment, good governance and notifying the Care Quality Commission (CQC) of relevant events and incidents. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements.

We undertook this focused inspection to check they had made improvements regarding the three breaches of legal requirements. This report only covers our findings in relation to those legal requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Addison Court on our website at www.cqc.org.uk.

Addison Court is a care home providing accommodation and personal care for up to 70 people who need nursing and personal care. It provides a service primarily for older people, including people living with dementia. At the time of the inspection there were 56 people accommodated there.

A manager was in post at the time of the inspection, however they had yet to become formally registered with CQC. They had applied to become registered and their application was being determined at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found some action had been taken to address previous concerns about safe care and treatment, but improvements were not consistent or sustained.

Improvements had been made to the way people were supported when using their wheelchairs. Foot plates were used when staff assisted people in their chairs to avoid the risk of foot entrapment.

Areas of concern remained. We found a significant delay from staff finding a person had developed a pressure ulcer to them implementing a care plan and monitoring the wound site. Records for the administration of topical medicines (creams applied to the skin) had long gaps. Instructions for how these medicines were used were not always clear. A person's pain was not well managed and a delay in this being raised and followed through with the person's GP was highlighted to the manager for immediate attention.

Improvements were still required to the governance of the service. The frequency of management audits for medicines and infection control, although undertaken, had reduced. Staff practice was not always improved when issues were identified. For example, hand hygiene and medicines storage issues identified through internal audits had not been resolved. Expected standards were not communicated to the staff team in a structured or consistent manner.

We found continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to safe care and treatment and good governance.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff supported people safely to use their wheelchairs.

There were gaps in topical medicines records. Instructions for their use were not always clear.

There was a delay in implementing a person's skin integrity care plan.

We could not improve the rating for: 'Is the service safe?' from 'requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service did not have a registered manager in post, although the manager had applied to become registered with CQC.

Systems to monitor and improve the quality of the service were not always effective. Minor issues identified at audits were repeated and not fully resolved, nor were improvements sustained.

We could not improve the rating for: 'Is the service well led?' from 'requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Addison Court

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Addison Court on 14 and 16 June 2016. This inspection was carried out to check that improvements to meet legal requirements had been made after our comprehensive inspection in October 2015. We inspected the service against two of the five questions we ask about services; 'Is the service safe?' and 'Is the service well-led?' This was because the service was not meeting legal requirements at the time of our initial 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.

This inspection was undertaken by one adult social care inspector. During the inspection we looked around the home, talked with three people using the service, three relatives, four staff, the acting manager, the provider's compliance manager and an operations manager after our visit. We reviewed a sample of care records. These included three people's care plans and their progress notes. We also reviewed their medication administration records. We examined a range of audits and cleaning records as well as statutory notifications and other management records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in October 2015 breaches of legal requirements were found. These included a failure to ensure suitable arrangements for the safe care and treatment of people using the service. At that time we found gaps in recording the administration of topical medicines (creams applied to the skin) which meant we could not be sure they were administered as prescribed. We found there were lengthy gaps in administration records, administration instructions were unclear, as were guidelines in people's care plans. We also saw staff did not always move people in their wheelchairs in a safe manner. Foot plates were not used by staff for two people when staff pushed their chairs, putting people at risk of foot entrapment. We reviewed the action plan the provider sent to us following the inspection. This included details of how they planned to comply with legal requirements.

During this inspection we spoke with a person who told us they were in pain. They said this was meant to have been raised with their GP, "ages ago". They told us they could not receive a specific medicine due to other health needs. A related care plan had been developed by staff. This stated, "If [name] complains of further pain despite receiving their regular pain relief to review with GP for stronger pain relief." We saw a review had been carried out in April 2016 and that there was to be liaison with the GP. No further action had been taken since that time. We discussed this with the manager to ensure this was raised promptly with the person's GP so that the person could be assessed for and receive suitable pain relief.

This person was reported by a nurse to have developed a grade two pressure ulcer on 29 April 2016. No care plan or steps to monitor the wound were introduced until a different nurse recorded the wound nine days later. A care plan and monitoring records were then introduced, however records of positional changes were inconsistent; sometimes recording the same position at subsequent entries or with lengthy gaps.

Some medicines applied to people's skin, such as barrier creams and emollients (moisturising and soap substitute creams) were administered by care workers, with separate records kept. These are called topical medicines. We sampled the administration records for 11 people. Unaccounted for gaps or inconsistent entries were evident in all the administration records we looked at. Administration instructions also remained unclear for several people, with no indication if the medicines were to be administered 'as required', or to be administered at particular times. For some people there were instructions as to where the creams were to be applied, but for others this was not the case. We looked at the corresponding administration records supplied by the pharmacist. For some people the topical medicines were not listed and where there were instructions these were often vague; simply stating 'as instructed'. Where nursing staff had made hand written entries, none of these had been countersigned to verify their accuracy. We looked in people's care plans to see if instructions for topical medicines had been included within medicines, skin care or personal hygiene care plans. We found staff had completed partial instructions either within skin care risk assessments or care plans.

This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we observed staff help people when using their wheelchairs. Staff explained to people what they were doing and only moved people when the foot plates were fitted. This meant the equipment was being used as designed; minimising the risks of accidental injury. Staff we spoke with were clear about the need to ensure foot plates were in place before pushing people in their wheelchairs.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in October 2015 breaches of legal requirements were found. We found audit and governance processes had failed to ensure satisfactory standards were maintained. Shortfalls identified in audits were not always addressed or improvement sustained. At that time we found audits and other quality checking systems were completed thoroughly, however there was evidence that the system did not always result in sustained improvements.

During this inspection the relatives we spoke with expressed mixed views about the leadership and management of the service. For example, one relative said if they had a complaint, "I'd go straight to the manager. They're always available." They confirmed the manager had a visible presence in the home, saying, "They're all over the place." Another relative described occasions when they had highlighted an area of concern, only for these to be repeated at later visits. They were concerned that although promises of improvement were made, there was not always a proactive approach taken to areas such as cleanliness and pressure area care.

Staff we spoke with made positive comments about the manager and said they retained a visible presence in the home. One staff member said, "[Name's] always on the floor." Another told us, "[Name] is around all the time. The head of care pops in and is only a phone call away." Staff were less clear about how expected standards were communicated to the team. Two explained that staff would be 'caught on shift'. Another said they always attended staff meetings and that updates on discussions at team meetings were passed on verbally to others. We saw the last meeting had been held in February 2016 and that attendance at such meetings was low. We highlighted this to the manager so they could review the mechanisms used to communicate within the home.

We found systems to assess, monitor and improve the quality of the service and manage risks were completed less regularly than at our last inspection and again did not always result in improvements being fully implemented and sustained. For example, infection control audits that had previously been carried out at regular intervals had only been undertaken once since our last inspection. An issue of staff having false or excessively lengthy finger nails, identified at previous audits, was again identified and also observed by us during this inspection. Furthermore, we checked shortfalls identified at the most recent medicines audit, and although fairly minor, some shortfalls continued. These included continued gaps in storage temperature records and staff failing to double sign for medicines received into the home. A health and safety audit completed by an external contractor had noted the need to ensure toiletries, chemicals and razors were removed from a shared bathroom on the first floor. We saw the two unlocked bathrooms were clear of all such items. Some toiletries and a disposable razor were evident in a third bathroom. Staff confirmed that this room remained locked when not in use, which it was on this occasion. Shortfalls in the recording of topical medicines identified at our previous inspection also continued, in spite of assurances that these would be resolved.

Other mechanisms, such as staff meetings, residents meetings, quality questionnaires and complaints, were used to identify improvements. Undertakings for improvement were sometimes made and actions

promised. However, these were not recorded in action plans where specific actions were described, individuals were not identified to take a lead in resolving issues, and target dates for monitoring progress or completion were not set. We advised the manager that they could consider developing a service improvement plan to bring together the various strands and help ensure an overall approach to continual improvement.

We found lower level concerns and complaints were not consistently recorded. Information and discussions described to us by a relative were not documented in the complaints system. Nor were they detailed in the relevant section of the person's care file. We requested the manager obtain and provide us with details of the discussions held, however this information was not.

This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection there was no registered manager in place. Although not registered at the time of this inspection, the manager had commenced the process of applying to become registered. The manager was present and assisted us with the inspection. They appeared to know the people using the service and the staff well and had a visible presence within the service. The manager was aware of the requirements to send the Care Quality Commission (CQC) notifications for certain events and had done so. When we last inspected we found some reportable events had not been notified to CQC, although the manager sent these to us retrospectively. On this occasion, with the exception of one incident, we found relevant matters had been notified to us.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured the proper and safe management of medicines. Regulation 12(1) and 12(2)(g).

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 or processes had not effectively assessed, monitored and improved the quality and safety of the service provided. Regulation 17(1)&17(2)(a)&(b)