Malhotra Care Homes Limited

# Addison Court

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

This was an unannounced inspection which took place on 22 November 2018. This meant the staff and provider did not know we would be visiting.

We inspected the service to follow up on the breaches from the previous inspection and to carry out a comprehensive inspection.

At the last inspection in August 2017 the service was not meeting all of the legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to regulation 18, staff training.

At this inspection we found improvements had been made and the service was no longer in breach of regulation 18.

Addison Court is a care home that provides accommodation and nursing or personal care for a maximum of 70 older people including people who may live with dementia. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. Addison Court accommodated 59 people at the time of the inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Appropriate training was now provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

People said they felt safe and they could speak to staff as they were approachable. People and staff told us they thought there were enough staff on duty to provide safe care to people. Staff knew about safeguarding procedures. Staff were subject to robust recruitment checks. Arrangements for managing people's medicines were safe.

Detailed records reflected the care provided by staff. Care was provided with kindness and people's privacy and dignity were respected. Communication was effective to ensure people, staff and relatives were kept up-to-date about any changes in people's care and support needs and the running of the service.

Staff were skilled and knowledgeable about each person they cared for and they were committed to making

a positive difference to each person. There was clear evidence of collaborative working and excellent communication with other professionals to ensure people's care and treatment needs were met.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Activities and entertainment were available to keep people engaged and stimulated.

The home was being refurbished and people were very positive about the changes taking place. There was a good standard of hygiene. The environment promoted the orientation and independence of people who lived with dementia.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people and family members and their views were used to improve the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Regular checks were carried out to ensure the building was clean, safe and fit for purpose. Risk assessments were up-to-date and identified current risks to people's health and safety. People received their medicines in a safe and timely way.

Appropriate infection control measures were in place and there was a good standard of hygiene.

### Is the service effective?

Good

The service was effective.

Improvements had been made to staff training. Staff received a range of training to give them an insight into people's needs.

People's rights were protected. Improvements had been made to best interest decisions so they were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet.
The home was being refurbished and the environment promoted the orientation of people who lived with dementia.

### Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were compassionate, kind and caring.

Good relationships existed and staff were aware of people's

needs and met these in a sensitive way that respected people's privacy and dignity.

People maintained they were kept involved in daily decision making.

## Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. There was a good standard of record keeping to ensure people's needs were met.

There were activities and entertainment to stimulate people and to keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

## Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was available to give advice and support.

Staff were aware of their rights and their responsibility to share any concerns about the care provided at the service.

The home had a robust quality assurance programme to check on the quality of care provided.

# Addison Court

**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 22 November 2018 and was unannounced.

The inspection team consisted of one adult social care inspector 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 for older people.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and other professionals who could comment about people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 13 people who lived at Addison Court, 11 relatives, the registered manager, the head of compliance, the head of care, the chef, five support workers, two activities co-ordinators and a visiting professional. We looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for four staff, four people's medicines records, staffing rosters, staff meeting

minutes, meeting minutes for people who used the service, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

# Is the service safe?

## Our findings

People who could comment told us there were sufficient staff and they felt safe. Their comments included, "I do feel safe living here", "I know about the buzzer-sometimes care workers come straight away, they are very good", "I have never had to buzz for help" and "I just need to shout and there is always someone about." Relative's comments included, "I think there are plenty of staff Monday-Friday, but not the same amount at a weekend" and "There are more staff than before." A staff member commented, "There are usually enough staff, we help each other out."

The registered manager told us staffing levels were determined by a dependency tool. This was used monthly to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely.

People were supported by two registered nurses, three team leaders one senior support worker and nine support workers. From our observations and people's feedback we considered that staffing levels were sufficient over the twenty-four period apart from for the top floor. Staffing levels were not sufficient to meet people's needs on this floor at all times. A team leader and one support worker were allocated to the floor to support 12 people. However, when the team leader was dealing with medicines, paperwork, liaising with visiting professionals and other senior duties they were not available to provide direct care to people and only one staff member was therefore available to support people. The head of care told us that this had been identified and a second support worker was to be allocated to this floor therefore three staff would be allocated to the top floor. We checked after the inspection and additional staff were in the process of being recruited.

Staff had receiving training about safeguarding and understood how to report any concerns. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse. They told us they would report any concerns to the registered manager or senior person on duty.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns.

Accident and incident reports were analysed, enabling any safety concerns to be acted on. Health and safety issues were discussed at meetings to raise staff awareness of complying with standards and safe working practices.

People were supported with their medicines safely. We observed part of a medicines round. A monitored dosage system was used to store and manage the majority of medicines. This is a storage device designed to simplify the administration of medication by placing the medicines in separate compartments according

to the time of day. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. All records seen were complete and up to date, with no recording omissions. Our check of stocks corresponded accurately to the medicines records. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment rooms. Records showed current temperatures relating to refrigeration were recorded daily. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

People's individual risk assessments were in place with a system of review to ensure they remained relevant, reduced risk and kept people safe. The risk assessments included risks specific to the person such as for moving and assisting, choking, nutrition and pressure area care. The monthly evaluations included information about the person's current situation. A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

There was a very good standard of hygiene around the home. Staff received training in infection control and protective equipment was available for use by staff as required.

Robust recruitment processes were in place. This included thorough checks of applicants for any role. The service ensured the correct information was available in personnel files. This included proof of identity, criminal history checks, and references from prior employers, job histories and health declarations. The service ensured only fit and proper persons were employed to care for people.

Records showed that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

# Is the service effective?

## Our findings

At the last inspection in August 2017 we had concerns that staff had not all received training about the Mental Capacity Act 2005.

At this inspection we found improvements had been made and the service was no longer in breach of this requirement.

The staff training matrix showed and staff told us they received training to meet peoples' needs and training in safe working practices. There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people and this included a range of courses such as mental capacity, fluids and nutrition, dysphasia awareness, diabetes, dignity, dementia awareness, basic life support, distressed behaviours and equality and diversity. Some staff had also achieved or were studying for a diploma in health and social care at levels two or three (previously known as the National Vocational Qualification, NVQ).

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. Staff undertook the Skills for Care, Care Certificate to further increase their skills and knowledge in how to support people with their care needs.(The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care). They told us they had opportunities for training to understand people's care and support needs and they were supported in their role. Their comments included, "We do e-learning and face-to-face training", "I have done a National Vocational Qualification [NVQ] at level two, [now known as the diploma in health and social care]", "There are excellent opportunities for training", "The registered manager does my supervision", "Supervisions happen every two months", "I get opportunities for professional development" and "We keep up-to-date with training."

Care provided by staff was holistic and included support for all areas of assessed need. Comprehensive assessments were carried out to identify people's support needs and safety requirements. They included information about their medical conditions, mental health, dietary requirements, safety, communication and other aspects of their daily lives.

People were supported to have their healthcare needs met. Their care records showed they had input from different health professionals. For example, the GP, speech and language therapist (SALT) and dietician.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be

deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that all DoLS applications were clearly documented and stored and that where people were being restricted or controlled then this was done in their best interests and the least restrictive option was always considered. We observed staff demonstrated a sound understanding of their duty to promote and uphold people's human rights. The registered manager had submitted DoLS applications appropriately.

Staff and relatives told us communication was effective to keep them up-to-date with people's changing needs. Staff comments included, "We have verbal and written handovers", "Morning staff get a handover from night staff" and "Communication is very good." A handover session took place, between staff, to discuss people's needs when staff changed duty at the beginning and end of each shift. This was to ensure staff were made aware of the current state of health and well-being of each person.

Systems were in place to ensure people received varied meals at regular times. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. A relative told us, "[Name] wasn't eating at home. They are now fed well and enjoy the food. They have put on weight since coming here." Records were up-to-date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Food and fluid charts recorded people's nutritional and fluid intake. However, food charts did not record portion size. We discussed this with the registered manager who told us it would be addressed immediately.

We observed the lunch time meals across the home. People enjoyed a predominantly positive dining experience. Food was well-presented and looked appetising. Their comments included, "The food is good", "If I don't like something I can always have an alternative" and "Food is as good as expected, no complaints." People were offered a choice of meal. However, although people were verbally offered a choice of meal, if a person was undecided or no longer understood the spoken word they were not shown two plates of the available meal to help them make the choice by smell and visually. Menus were not available in an accessible format to help keep people informed, pictorial menus were not available and the written menus were in small print. We discussed this with the registered manager who told us it would be addressed.

The meal time was relaxed and unhurried. People sat at tables that were well set with tablecloths and condiments and staff remained in the dining areas to provide help and support to people. Some people remained in their bedrooms to eat. Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. Staff talked to people as they helped them and as lunch was served.

The home was spacious, bright and airy. The home was being refurbished and several communal areas and bedrooms had been re-decorated and flooring replaced. The registered manager told us refurbishment was on-going and there were plans to create tea-rooms and a bar to improve people's social engagement. There was appropriate signage around the building to help maintain people's orientation. Lavatories and bathrooms were signed for people to identify the room to help maintain their independence. Memory boxes were available that contained items and information about people's previous interests to help them identify their room. The registered manager had many ideas and plans to ensure the environment was themed and of interest to maintain the engagement of people who lived with dementia.

Good

# Is the service caring?

## Our findings

The atmosphere in the home was calm, friendly and welcoming. People who used the service and relatives we spoke with were very positive about the care and support provided. Their comments included, "Staff are very caring", "Staff are very helpful", "On the whole staff do their job well." "Carers are good and kind", "Care staff are wonderful, I have a few favourites" and "Care staff are good, I like to stay in my room, they often come in to see I am okay." Several compliments and cards of appreciation had also been received commending staff on the care provided.

There was a stable staff team with some staff having worked at the service for several years. Positive, caring relationships had been developed with people. Staff interacted with people in a kind, pleasant and friendly manner. Care plans were written in a person-centred way, outlining for the staff how to provide individually tailored care and support.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

Staff received training in equality and diversity and person centred approaches to help them recognise the importance of treating people as unique individuals with different and diverse needs.

People's care records contained information about people's likes, dislikes and preferred routines. This information helped to ensure staff provided person-centred care when the person was unable to tell staff about their routines and how they wanted their care to be delivered. Examples included, "Likes coffee and chocolate", "[Name] used to like to travel so has an atlas to look at in their room", "[Name] has made us a bird feeder and staff need to encourage them to go out and fill it every other day."

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, what to eat, when to get up and go to bed and what they might like to do. For some people who needed encouragement to be involved in decision making some care plans detailed how a person may be encouraged and involved in decision making.

Some information was accessible and was made available in a way to promote the involvement of the person. For example, by use of pictures or symbols for people who did not read or use verbal communication. A relative told us, "[Name] has problems with their vision. One of the staff got them a book with bigger print as [Name] likes to read, couldn't get any better." Menus and activities although available in written format were small and difficult to read, and accessible information advertising activities and days of the week and other information to keep people informed and involved was not available. We discussed this with the registered manager who told us it would be addressed.

All people's records advised staff how to communicate with the person. Communication care plans were in place for some people that provided information about how a person communicated. Examples included, "[Name] can acknowledge communication with eye contact and the occasional nod", "[Name] is able to communicate if they are feeling unwell and needs pain relief" and "Give me eye contact, speak at a steady pace and not too fast."

People's privacy and dignity were respected. One person told us, "I have privacy when bathing, the care staff help me into the bath and once safe I am left for a short while with easy access to the pull cord to ring." We observed that people looked clean, tidy and well-presented. Staff knocked on people's doors before entering their rooms. Bedroom doors were closed when staff assisted people in their bedroom to protect their dignity. Records were held securely and policies were available for staff to make them aware of the need to handle information confidentially.

Written information was available that showed people of importance in a person's life. Relatives were involved in discussions about their family member's care and support needs and they could approach staff at any time. One relative told us, "We were involved in [Name]'s care plan, very accommodating and we are kept up to speed."

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Good

# Is the service responsive?

## Our findings

Two activities personnel were employed and an external community project visited regularly to carry out activities with people and keep them engaged if they wished to be involved. A person commented, "The activities person knows what suits me." A relative told us, "[Name] loves to play dominoes and can have their usual can of beer or glass of vodka before they go to bed. They still get this, the same as at home." An activities programme was available that advertised daily activities. Activities included, story-telling, word searches, quizzes, cinema, poets corner, Christmas activities, Christmas shopping, arts and crafts, reminiscence, knitting, arm chair exercises, pamper sessions, sing-a-long and film afternoons. We saw a variety of seasonal entertainment was arranged for over the Christmas period including a Christmas party, local school choir and entertainers. The hairdresser visited weekly and a local member of the clergy visited regularly. People confirmed activities, seasonal entertainment, parties and organised trips took place. The head of care informed us the provider had purchased a fleet of mini buses to be shared across their homes. This would help people to access the community more easily.

There was a lively atmosphere on the different floors of the home. We observed people were sitting in communal areas in between mealtimes. Staff engaged with people and had meaningful conversations with them.

Care plans were developed from assessments that outlined how people's needs were to be met. For example, with regard to nutrition, personal care, medicines, pressure area care, communication and moving and assisting needs. Records showed that monthly assessments of people's needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Records showed that reviews of people's care and support needs took place with relevant people at intervals. A relative commented when asked if they had attended any reviews, "When the new manager started we were called in to go through [Name]'s care plan." Another relative said, "We were involved with [Name]'s care plan."

Care plans were in place that provided details for staff about how the person's care needs were to be met. For example, a personal hygiene care plan stated, "[Name] is able to dress themselves, does require some assistance with their compression socks." We advised care plans could be broken down further to provide guidance to staff to ensure consistent care was provided to people detailing what the person could do to be involved and to maintain some independence. Other care plans for personal hygiene which stated the person became distressed did not document what staff needed to do to de-escalate the situation when a person became agitated because of personal care interventions. We discussed this with the registered manager who told us it would be addressed.

Records also detailed people's social interests. Examples included, [Name] reads a daily newspaper in their room" and "[Name]'s favourite author is Martina Cole."

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not

attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs. Information was available with regard to people's spiritual and cultural preferences at this important time and for their wishes after death to ensure their final wishes could be met.

Staff completed a daily accountability record for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans. Charts were also completed to record any staff intervention with a person. For example, when personal hygiene was attended to and other interventions to ensure people's daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs.

People knew how to complain. People we spoke with said they had no complaints. Their comments included, "I can't complain", "If I have a problem one of the care staff will sort it for me, they're very good", "No complaints" and "If I have a query it's sorted straight away." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and four had been received since the last inspection and they had been appropriately investigated.

Good

# Is the service well-led?

## Our findings

The home had a registered manager who was experienced in managing care services for older people. They had become registered as manager for Addison Court in August 2018. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

The registered manager was enthusiastic and had introduced ideas to promote the well-being of people who used the service. Staff we spoke with were positive about their management and had respect for them. Several staff commented, "The manager is very approachable." Other comments included, "I love working here", "We made several complaints previously but everything is a lot better with the new manager", "Noticeable improvement since the new manager started in particular with cleanliness and efficiency", "Seem to be more staff around, difficult to speak to anyone previously" and "I'm quite happy."

The atmosphere in the home was lively and friendly. People told us the atmosphere was inviting and relatives and visiting professionals said they were always made welcome. Staff, people and relatives said they felt well-supported.

The registered manager, head of care and head of compliance assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and management team were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The registered manager said they were well supported in their role by the provider and the provider's management team. They told us they subscribed to a range of care industry and related publications and kept up-to-date with best practice and initiatives. These included links with the Alzheimer's Society and the Tyne and Wear Care Alliance, an employer-led body that supports workforce development in the independent care sector.

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Staff told us meeting minutes were made available for staff who were unable to attend meetings.

A regular news letter was published by the provider to inform people and staff of what was happening across the organisation. It also advertised the employee award scheme and had a social aspect as it advertised events and shared news and stories around the services.

Auditing and governance processes were robust within the home to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. All audits showed the action that had been taken as a result of previous audits. A monthly risk monitoring report that included areas of care such as safeguarding, complaints, infection control, pressure area care and serious changes in a person's health status was completed by the home and passed to head office for

analysis.

The head of compliance told us monthly audits were carried out and the results were signed off by the head of care. Monthly audits included checks on care documentation, staff training, medicines management, home presentation, complaints management, health and safety and accidents and incidents. Other audits included for health and safety and infection control.

Records showed monthly visits were carried out by a representative from the compliance team to speak with people and the staff regarding the standards in the home. Reports showed they also audited a sample of records, such as care plans, complaints, accidents and incidents, risk assessments, social activities, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. Action plans were produced from monthly visits with timescales for action where deficits were identified. Recent reports showed the improvements that had been made to help ensure the service was run for the benefit of people who lived there and to ensure they were safe and comfortable.

Feedback was sought from people through meetings and surveys. Feedback from staff was obtained in the same way, through regular staff meetings and surveys. We saw the results of the 2018 survey was predominantly positive and where any areas of improvement were identified an action plan was drawn up.