

Malhotra Care Homes Limited

# Covent House

## Inspection report

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## Ratings

Overall rating for this service

Good ●

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 inspection took place on 7 and 12 September 2018. The first day of the inspection was unannounced. This meant the staff and provider did not know we would be visiting.

Covent House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Covent House accommodates 63 people in one purpose built building. The home has five floors, four of which provide accommodation for people with nursing and personal care needs. Some of the people using the service were living with dementia.

The service did not have a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. Like 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. A new manager was in post who had applied to be registered with CQC.

Covent House was last inspected by CQC on 1 August 2017 and was rated Requires improvement. At the inspection in August 2017 we identified the following breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment), Regulation 13 (Safeguarding service users from abuse and improper treatment) and Regulation 17 (Good governance).

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Effective, Responsive and Well-led to at least good. At this inspection we found improvements had been made in all the areas identified at the previous inspection.

Accidents and incidents were appropriately recorded and investigated. Risk assessments were in place for people who used the service and described potential risks and the safeguards in place to mitigate these risks.

The manager and staff understood their responsibilities with regard to safeguarding and had been trained in safeguarding vulnerable adults.

Medicines were stored safely and securely. Procedures were in place to ensure people received medicines as prescribed and regular audits were carried out.

The home was clean, spacious and suitable for the people who used the service. Appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff. Staff were supported in their role via appropriate training and regular supervisions.

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 were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at Covent House. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they started using the service and support plans were written in a person-centred way. Person-centred is about ensuring the person is at the centre of any care or support and their individual wishes, needs and choices are taken into account.

Activities were arranged for people who used the service based on their likes and interests, and to help meet their social needs. The service had good links with the local community.

People who used the service and family members were aware of how to make a complaint. The provider had an effective quality assurance process in place. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

## 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.

Staffing levels were appropriate to meet the needs of people who used the service and the provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and investigated, risk assessments were in place and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

### Is the service effective?

Good ●

The service was effective.

Staff were suitably trained and received regular supervisions and appraisals.

People's needs were assessed before they began using the service and people were supported with their dietary needs.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

### Is the service caring?

Good ●

The service was caring.

Staff treated people with dignity and respect and people's independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People were involved in their care and their wishes were taken into consideration.

### Is the service responsive?

Good ●

The service was responsive.

Care records were up to date, regularly reviewed and person-centred.

The home had a full programme of activities in place for people who used the service.

The provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

**Is the service well-led?**

**Good** ●

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

The service had good links with the local community.

# 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 7 and 12 September 2018 and was unannounced. One adult social care inspector, a specialist advisor in nursing and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

During our inspection we spoke with six people who used the service and five family members. We spoke with the manager, provider, head of compliance, head of care, three nurses, two care staff, a domestic member of staff, two activities co-ordinators and one maintenance member of staff. We looked at the care records of four people who used the service and the personnel files for four members of staff.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We contacted professionals involved in caring for people who used the service, including local authority commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

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.

# Is the service safe?

## Our findings

People felt safe at Covent House. They told us, "I feel safe and comfortable here because when I was at home on my own I was frightened especially at night", "I feel very safe here especially at night", "I am safe and well looked after by the girls here" and "I have my own room and can lock the door if I need to or want to."

At the previous inspection we found medicines were not always managed safely for people and records had not been completed correctly. At this inspection we found medicines were stored safely and securely, and room and refrigerator temperatures were monitored to ensure medicines were stored at the correct temperature.

Medication administration records (MAR) were checked. A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration. Each MAR included a photograph of the person and any allergies were recorded. No omissions were noted in the records we viewed.

Staff were appropriately trained in the administration of medicines and received regular competency checks. The provider had a robust medicines auditing process in place, which identified any errors with the administration of medicines in a timely manner. Although it wasn't an error, we did identify a recording issue for one particular medicine. We discussed it with the manager who agreed the way the medicine administration had been recorded on the MAR could be confusing and would action with the staff member involved.

We looked at the administration records for a medicine that should be given 30-60 minutes before food. Staff we spoke with could not confirm the medicine was always being administered the sufficient length of time before the person had breakfast. We discussed it with the manager who agreed to action and ensure all staff were aware.

There was clear individual guidance on the administration of 'as and when required' medicines, otherwise known as 'PRN' medicines that described the circumstances in which the medicine could be administered and the amount that could be administered.

Some people were given their medicines covertly. Covert medicines are the administration of any medicine in a disguised form. A clear best interests process had been followed to arrive at the decision to administer covertly, including evidence of consultation with health care professionals, family members and in one case, a legal representative.

We observed a medicines administration round at lunch time. We observed it was carried out safely and competently. Clear explanations were provided and people were given plenty of time to take their medicines.

At the previous inspection we found areas for improvement had been identified following safeguarding incidents and actions to improve processes were being implemented. At this inspection we found safeguarding related incidents had been appropriately recorded and notified to the local authority. Where changes in policy or lessons learned had been identified, actions had been put in place. For example, agency staff always to work with a permanent member of staff for continuity reasons. Staff we spoke with demonstrated a good awareness of safeguarding and whistleblowing. They were able to articulate key issues to consider in relation to potential abuse by either staff or family members, and felt confident they could raise issues with the manager regarding standards of care.

At the previous inspection we found some risk assessments were not in place or up to date. At this inspection we found risk assessments were regularly reviewed and up to date. These included nutrition, tissue viability, falls, mental capacity, choking, continence and personal hygiene. These described the potential risks and the safeguards in place to reduce the risk.

Accidents and incidents had been appropriately recorded and a checklist had been introduced to ensure each accident or incident had been appropriately investigated and dealt with.

Staff recruitment records showed that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. Copies of application forms were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. Checks had been carried out to ensure nurses were registered with the Nursing and Midwifery Council (NMC) and these registrations were in date.

We discussed staffing levels with the manager and looked at staff rotas. The service had an ongoing recruitment process and some night nursing shifts were being covered by agency staff. We asked staff whether there were plenty of staff on duty. They told us, "Okay", "No particular problems" and "We have busy periods, but we have a good team of staff who work well and are flexible and help each other." People and family members we spoke with did not raise any concerns about staffing levels. Our observations confirmed there were enough staff on duty with the right experience and knowledge to meet people's needs.

The home was clean, spacious and suitable for the people who used the service. Nursing and care staff were observed to wash their hands before and after all aspects of care, medicine administration and the serving of meals. There were sufficient supplies of gloves, aprons and hand hygiene gel available around the home.

Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Portable Appliance Testing (PAT), gas servicing and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, a fire risk assessment was in place, fire drills took place regularly and equipment checks were up to date. Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant that checks



were carried out to ensure that people who used the service were in a safe environment.

## Is the service effective?

### Our findings

People who used the service received effective care and support from well trained and well supported staff. One person told us, "I'm well looked after." Family members told us, "[Name] is very well looked after", "I know my [family member] is looked after and well cared for all the time here", "The staff appear to be well trained and know what they are doing" and "My brother always speaks well of the carers, they are always friendly."

At the previous inspection we found the principles of the Mental Capacity Act 2005 (MCA) were not being followed in relation to mental capacity assessments and best interest decisions. The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection we found the provider was following the requirements in the DoLS. The manager maintained a record of all DoLS applications. Care records included support plans for each individual that a DoLS application had been made for. This included the date of the application and clearly explained what could and could not be done under DoLS.

Mental capacity assessments and best interests decisions were appropriately recorded. Staff had received appropriate training and written guidance, and those we spoke with demonstrated a good understanding of mental capacity and DoLS. A mental capacity review tool was completed to ensure each person's file had been reviewed and people's rights to make decisions were upheld, decisions were specific and that relevant people were involved.

The service had sought consent from people for the care and support they were provided with, allowing access to records, photography, the administration of medicines and the use of bedrails where necessary.

Some of the people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records were up to date and showed the person and family members had been involved in the decision making process.

The majority of staff mandatory training was up to date. Where it was due, we saw it was planned. Mandatory training is training that the provider deems necessary to support people safely and included infection control, fire safety, nutrition, health and safety, first aid, equality and diversity, safeguarding, moving and handling, and mental capacity. Staff told us there were no problems accessing training courses

and had received appropriate training relevant to their role.

New staff completed an induction to the service and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Staff received regular supervisions and appraisals. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace.

People's needs were assessed before they started using the service. Records included pre-admission assessments that were completed thoroughly and contained the basis from which an initial support plan could be formulated prior to admission.

People had access to a choice of food and drink throughout the day. Staff regularly ensured people had the opportunity for a hot or cold drink. People who had specific dietary or fluid intake needs had intake record sheets that were monitored by the nurse in charge. Malnutrition Universal Scoring Tools (MUST) were used to identify people at risk of malnutrition. People's weights were monitored closely and guidance had been sought from dietitians and speech and language therapists (SALT) where required.

We observed lunch and saw staff supporting people who required assistance. Staff wore appropriate protective clothing and offered aprons and wipes to people who wanted them. People were served in a timely manner and clearly enjoyed their meal. Staff spoke with people throughout, asking them if they were okay and whether they would like anything else. We also saw people were supported to eat in their own bedrooms if they preferred. People told us they enjoyed the food at Covent House. They told us, "The food here is good, sometimes too much" and "We do have a choice."

People had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including SALT, dietitians, district nurses, GPs and podiatrists.

Some of the people who used the service were living with dementia. We looked at the design of the premises for people with dementia and saw it was suitably designed to aid people's orientation around the home. There was plenty of signage in place and bathroom and toilet doors were easily identifiable. People who wanted them had memory boxes outside their bedroom doors. There were tactile displays on the walls, as well as pictures of butterflies and photographs of famous music and movie stars.

## Is the service caring?

### Our findings

People who used the service and family members were complimentary about the standard of care at Covent House. People told us, "They [staff] are very caring" and "The staff here really care and have time to pop in to see if I am alright."

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and people were assisted by staff in a patient and friendly way. We observed and heard staff laughing and joking with people.

People's preferences were documented in their care records. For example, "[Name] prefers to have a bath", "[Name] would like her hair done by the in-house hairdresser once a week" and "[Name] has some lovely clothes and likes clothes to co-ordinate."

Staff respected people's privacy by knocking on doors before entering rooms and closing bathroom and toilet doors when people went in. People told us, "Staff always close the bathroom door when I have a shower" and "I like a towel wrapped around me when I come out." A family member told us, "I have no concerns [with privacy and dignity]." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

Staff supported people to be independent and people were encouraged to care for themselves where possible. Care records described how staff were to promote independence. For example, "[Name] likes to have a body wash each day, which she can do herself with prompts", "Staff are to support [name] with her personal care, whilst also promoting independence" and "Staff are to offer prompts in order to support [name] with her needs."

Communication support plans were in place that described how people were given information in a way they could understand and the level of support they required with their communication needs. For example, "[Name] can communicate her needs at present but due to her diagnosis of dementia, may at times become a little confused. Staff are to support [name] if she does become confused on a one to one basis" and "Staff are to prompt [name] to wear her hearing aids."

Care records included spiritual assessments that recorded whether people had any spiritual or religious needs. Regular church services took place at the service for those people who wanted to attend.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Information on advocacy services was made available to people who used the service. Advocates help people to access information and services, be involved in decisions about their lives, explore choices and

options and promote their rights and responsibilities. The manager and activities co-ordinator told us none of the people at the time of the inspection were using independent advocates.

## Is the service responsive?

### Our findings

At the previous inspection we found some care records did not include the information needed to ensure safe care and treatment was provided, and were not always person-centred.

At this inspection we found care records were person-centred. Person-centred means the person is at the centre of any care or support and their individual wishes, needs and choices are taken into account. Each record included important information about the person, such as contact numbers and details of family, friends and professionals involved, as well as who to contact in urgent situations. 'This is me' profiles provided information on the person's personal history, as well as their likes and dislikes.

Support plans included medicines, communication, dementia, pain, nutrition and hydration, constipation, personal care, mobility and falls, social care, sleeping, end of life, and safe environment. Records were comprehensive, regularly reviewed and up to date.

For example, appropriate guidance was in place for people at risk of skin breakdown or pressure sores. Records described the action staff were to take to reduce the risk of pressure damage and specific tools were used to calculate the risk. Records described the 'at risk' status of the person and support plans reflected this. Where required, we saw guidance had been sought from health care professionals and this was included in the care records. Appropriate risk assessments were in place where required.

At the time of inspection no one was receiving formal end of life care however people had end of life support plans in place that recorded people's preferences. End of life care was discussed with staff, who described recent examples of end of life care provided. They felt that good end of life care was provided and felt confident in their roles around this. The service maintained a palliative care register, which formally but sensitively captured people's end of life preferences and wishes.

We found the provider protected people from social isolation. Activities were planned based on people's likes and interests. The 'This is me' profiles were used to find out about people's past, interests, family, likes and dislikes. Daily activity records documented the activities people had taken part in and enabled family members to monitor. Monthly activity evaluation sheets were completed and used to identify the activities that people had enjoyed and to see if levels of participation had changed so that people did not become excluded.

Activities at the service included coffee mornings, exercise, baking, gentleman's club, pamper days, crafts, film afternoons and entertainers. The service was part of the 'Care homes choir', which was a collaboration between care homes in Gateshead and took place fortnightly. Dementia themed activities took place such as therapeutic activities, doll therapy, food tasting sessions and music therapy.

The provider's complaints policy and procedure was on display. A complaints log was maintained and included records of the formal complaints received in 2018. Each complaints record included details of the complaint, complainant, action taken and outcome. All the complaints we viewed had been satisfactorily

resolved. Complaints were audited monthly to ensure they had been appropriately dealt with.

## Is the service well-led?

### Our findings

At the time of our inspection visit, the service did not have a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. A new manager was in post who had applied to be registered with CQC.

At the previous inspection we found that although quality assurance systems had identified some areas for improvement and an action plan had been implemented, some actions had not been completed and some concerns had not been identified. At this inspection we looked at what the provider had in place to check the quality of the service, and to seek people's views about it. We found the provider had robust quality monitoring processes in place.

Regular audits of the service were completed by the provider's head of compliance. These included a review of feedback from meetings and surveys, activities, care records, health interventions, medicines, staffing, catering, maintenance and safety, and regulatory visits. Where issues were identified, actions were in place and we saw previous actions had been completed.

A variety of monthly audits were carried out and were up to date. These included an overall quality audit and audits of the dining experience, nutrition, prevention and control of infection, catering, pressure care, care records, and medicines. A new tool for auditing care records had been introduced. This ensured individual staff were given actions to correct any errors or omissions and these were checked to ensure they had been completed. Records we viewed were up to date.

The manager conducted a daily walkaround of the service and recorded their findings on a daily monitoring tool. This included checks of the environment, health and safety, and ensuring staff were actively engaging with people with respect and dignity.

Regular surveys were carried out and meetings took place where people and family members could feed back on the quality of the service, and discuss any issues or comments they may have. We saw the chef had been invited to attend one meeting following the results of a recent survey where some people had commented that they didn't always enjoy their meals. The chef noted people's comments and suggestions for planning future menus.

We spoke with the manager and provider about what was good about their service. The provider told us, "We are a family at Prestwick" and they were "very proud" of their staff.

A monthly newsletter was produced to provide people and family members with an update about what was going on at the home.

Staff told us, "It's a lovely home", "It's the first nursing home I have worked in as a nurse, and it can be challenging, but I enjoy it" and "I prefer it to hospital to give time to residents."



Staff were regularly consulted and kept up to date with information about the home and the provider. We saw records of staff and heads of department meetings. Staff we spoke with felt supported by the manager and told us they were comfortable raising any concerns. They described the manager as being "easy to approach" and "supportive of change".

The service had good links with the local community. A local junior school visited three times per year to sing and chat with people. A senior school placed students at the home for work experience. The service had good links with local churches and groups, such as the Alzheimer's Society. People visited Beamish Museum regularly and made use of the memory boxes provided by the museum.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.