Malhotra Care Homes Limited

Addison Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Addison Court is a residential care home providing personal and nursing care to up to 70 people. The service provides support to older people, some of whom were living with dementia. At the time of our inspection there were 62 people using the service.

People's experience of using this service and what we found
The provider did not always act robustly to investigate and support people raising concerns about their care. The safeguarding log did not accurately record action taken or lessons learnt from reviewing safeguarding concerns. The provider did not always ensure risks were assessed and mitigated. Although sufficient numbers of staff were on duty. On the days of the inspection the use of agency staff had increased. These staff told us that they did not know people's needs well enough. The provider did not recruit new staff in line with the regulations and their own procedures. People and relatives gave mixed feedback about staffing levels.

The provider's quality monitoring systems had not been used effectively to ensure trends were identified, fully investigated and lessons learnt following incidents, accidents and falls. Records did not demonstrate complaints had been fully investigated. Duty of candour requirements were not always followed and there had been a lack of management oversight at the service.

The provider's staffing dependency tool did not account for all factors which impacted on staffing levels. We have made a recommendation about this.

Improvements were required to ensure people had a positive mealtime experience. Records did not always demonstrate how staff supported people to achieve their target fluid levels. We have made a recommendation about this.

Care reviews, involving relatives where appropriate, had not been carried out as planned. Some care plans were not up to date or contained conflicting information.

Staff spoke positively about the people they supported. They told us the care at the home was good enough for their family or friends. Three staff had been nominated for an "Angel award" in recognition for their outstanding contributions to the local community.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Checks were completed to maintain a safe environment. Staff knew about the whistle blowing procedure and were confident to raise concerns. Staff followed good infection prevention and control (IPC) practices.

People were supported to access healthcare services in line with their particular needs.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 27 October 2022).

Why we inspected
This inspection was prompted by a review of the information we held about this service. The inspection was also prompted in part due to concerns received about staffing levels, moving and assisting, recruitment and management oversight. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report. Please see the safe, effective, caring, responsive and well-led sections of this full report.

Enforcement and recommendations
We have identified breaches in relation to person-centred care, safe care and treatment, safeguarding, complaints, good governance, fit and proper persons employed and duty of candour.

Following our inspection, we have issued the provider with a Warning Notice relating to the breach associated with fit and proper persons employed.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

Addison Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 3 inspectors, a medicines 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.

Service and service type
Addison Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Addison Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. The registered manager was absent during the inspection.

Notice of inspection
The inspection was unannounced. Our first visit was out of hours so we could assess the night-time staffing situation.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 15 people who lived at the service and 7 relatives. We spoke with 16 staff; the director of care, the head of compliance, the compliance manager, the operations manager, 1 nurse, 2 senior care workers, care workers, housekeeping staff, maintenance staff and activities coordinators. We reviewed a range of documents relating to the safety and management of the home. This included 10 medicine administration records and associated care plans, a further 6 care plans and 5 staff recruitment files. We also reviewed medicine audits completed by the service. 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.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- People were not always safeguarded from abuse and avoidable harm.
- The provider referred allegations of abuse to the local authority safeguarding team. However, immediate action was not always taken to keep people safe. One person raised concerns with staff, but these were not investigated impartially and robust action was not taken to keep the person, and others, safe.
- The provider's safeguarding log did not include all safeguarding incidents or record what actions had been taken, the outcome of the safeguarding referral and any lessons learned.

The failure to ensure safeguarding allegations were appropriately managed and monitored was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff knew about the whistle blowing procedure. They confirmed they would be confident to raise concerns, if required.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
- The provider did not adequately assess and manage risks to ensure people were safe or learn lessons when things went wrong.
- Accident records were completed for falls that occurred in the service. However, investigation reports were not available for all falls recorded. Post fall assessment tools (FPFATs) were used to monitor people for 24 hours after they had a fall. Most of these had not been completed for the full period specified on the tool.
- The provider regularly reviewed falls, incidents, accidents and safeguarding concerns. However, the analysis did not always identify and investigate trends, to ensure lessons were learnt and appropriate action was taken. For example, exploring why falls had increased significantly between June 2023 and July 2023, or why more falls happened at a particular time of day.
- The monthly incident and accident analysis had failed to explore other trends, such as unexplained bruising and minor injuries. There was also no incident and accident analysis available for October 2023.

The failure to analyse and properly review information to ensure action was taken to help prevent any recurrence was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider carried out a range of health and safety related risk assessments and checks to maintain a safe environment.

Staffing and recruitment

● The provider did not operate safe recruitment processes.
● Recruitment checks did not always comply with regulatory requirements or follow the provider's own recruitment processes. Some references were not suitable, or applications forms had not been fully completed. For example, 1 reference was unreadable, 2 references had not been received for 2 out of 5 staff and full employment/education histories were not available for 2 out of 5 staff.
● All references we viewed had not been verified, which was not in line with the provider's recruitment policy.

The failure to ensure new staff were recruited safely was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Whilst there were sufficient numbers of staff on duty; due to workforce pressures affecting adult social care services, the use of agency staff had increased. These staff were less familiar with people's needs and we found some agency staff had not been safely recruited. People and relatives told us the permanent staff were skilled and knowledgeable about people's needs. However, they were not as positive about the skills of the agency staff.
● People and relatives gave mixed views about staffing levels in the service. One relative said, "If [family member] rings their buzzer staff respond fairly quickly." Another person said, "They could do with more staff."
● Induction records were not available for all agency staff working when we visited. One agency staff member commented they had not received a handover and were not aware of specific strategies to support people when they were distressed. Another agency staff member told us they were not familiar with another person's care around their specific health related needs.
● The provider's staffing tool did not accurately assess the staffing levels at the home. Duties such as medicines management, care planning and other tasks such as attending meetings were not included on the staffing tool.

We recommend the provider reviews their staffing tool to ensure it effectively assesses staffing levels, skills and knowledge to make sure there are sufficient staff deployed who understand people's needs.

Using medicines safely
● Medicines were not safely managed. Records did not assure us that oral medicines were administered as prescribed. For example, we found missed doses with no explanation. One of these medicines was also a critical medicine for Parkinson's.
● Topical medicine (creams) records did not assure us topical medicines were applied as prescribed. For example, some topicals medicines were not recorded as being applied and others were not being applied at the correct frequency.
● Medicines used to thicken food and fluids were managed appropriately however we found fluid targets were not being met with no explanation given as to why.
● We found handwritten entries were double signed, however the warning labels to help keep people safe were not transcribed. This was not in line with NICE guidance.
● The processes to safely administer when required medicines was not robust, for example we found some when required medicines had no guidance in place, instructions were incorrect or contained very minimal person specific information to support staff in their administration. We also found inconsistent recording of why they had been given or if they had been effective.

The failure to ensure the proper and safe management of medicines was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were stored securely, and we found evidence of temperature monitoring in the service.

Preventing and controlling infection

● People were protected from the risk of infection as staff were following safe infection prevention and control (IPC) practices. Staff used PPE correctly and good hygiene practices were promoted throughout the home.

● Staff understood the importance of good hygiene and followed the provider's IPC procedures.

● The provider followed Government guidance in relation to visiting Addison Court. There were currently no restrictions in place.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were not always assessed effectively to ensure care and support was always delivered in line with current standards.
- Records did not always demonstrate people's care was delivered in line with best practice guidelines. We identified shortfalls around the management of safeguarding and the management of risk.
- People's oral healthcare needs had been assessed. The information gathered had not been used to develop personalised oral healthcare plans.

The failure to ensure an effective system was in place so care was assessed and delivered in line with best practice guidance was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to eat and drink enough to maintain a balanced diet
- Records relating to people's hydration needs did not always show how staff supported them to achieve their target fluid intake levels. In addition, records relating to one person's risk of malnutrition did not demonstrate that the person's care plan had been followed.
- People's lunch time experience was at times task orientated and disorganised, rather than person-centred. Other people had to wait for support to eat their meal. One staff member told us, "There needs to be more organisation at mealtimes." Staff tried hard to meet people's needs and there were some aspects of good practice, such as showing people plates of food so they could choose.
- People gave positive feedback about the quality of the meals they received and the choices available. One person said, "(The chef) would prepare stuff I had asked for. I am happy with what is provided."

We recommend the provider reviews and implements best practice guidance relating to person-centred support around mealtimes.

Staff support: induction, training, skills and experience
- The service ensured staff had the skills and experience to deliver care and support. However, records of an appropriate induction were not available for some agency staff, and we could not be assured they knew people's needs well enough. The operations manager was looking further into this.
- Staff told us they received the training and support they needed. Training and one to one supervisions were up to date.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were supported to access healthcare services and support. Care records showed people had been referred to external health care professionals when needed. Health professionals visited the service regularly to provide care and treatment. However, one person's care plan had not been updated following a recent visit by a health professional.

Adapting service, design, decoration to meet people's needs

● People's individual needs were met by the adaption, design and decoration of the premises.

● The environment was welcoming and spacious. It had been adapted and was appropriate for the needs of people living with dementia, such as signage to help people orientate around the home. There were various communal spaces for people to enjoy.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

● Staff had completed training on the MCA.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● An effective system was not in place to demonstrate people and their relatives, where appropriate, were involved in their care.
● Records did not demonstrate care reviews had been carried out as planned. Some people's care review forms were blank. One relative told us they had not felt involved in their family member's care until senior management became involved during this inspection.

The failure to ensure an effective system was in place to support people and their relatives to be involved in their care was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Management explained that care reviews had temporarily been stopped during COVID-19, however, these should have been restarted. They explained that this would be addressed.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
● People were not always well supported and treated with respect by staff. Staff interactions with people were often inconsistent. Some staff interacted positively and engaged well, whilst others focused on the task they were doing, such as writing up care notes rather than interacting with people.
● Staff were not always attentive to people's mood or needs. Two people were sat in a lounge with their backs to the TV, so they would be unable to watch it if they wanted. On other occasions a carer was sat in the communal lounge but was disengaged with the people in there.
● Some of the language used in care records was not always person-centred or respectful. The senior management team told us this would be addressed.

The failure to ensure people received person-centred care was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Most people and relatives gave positive feedback about the care provided at Addison Court. One person commented, "I'm as happy as I can be here. The staff are good they help me if I need help."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
- An effective system to ensure records demonstrated how complaints and concerns were responded to was not fully in place.
- One relative told us they had not received an outcome to a complaint they had made. A relative commented, "[Family member] made the complaint to the manager. [Family member] got fobbed off … things don't get dealt with."

The failure to ensure records demonstrated how complaints and concerns were responded to was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
- An effective care planning system was not fully in place. Care plans were not always up to date. It was also not always clear how people, or their families, had been involved in their care and support.
- For one person with complex health needs, care plans contained contradictory information about the care required from care staff.
- Some people's care files contained useful content from behavioural specialists to guide staff about the most effective strategies to support people when they were distressed. However, some agency staff told us that they were unsure how to support people when they were distressed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
- An activities programme was in place. Two activities coordinators were employed. A birthday and wedding anniversary were being celebrated during our visits to the home.
- Activities were on-going during our second visit to the home. However, on the third day, the activities co-ordinator was helping in the kitchen due to staff shortages.
- We received mixed feedback about the provision of activities. One person told us they had enjoyed the Halloween Party recently. Another person commented, "It's so boring in here."

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Information could be made available in different formats depending in people's needs.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's quality monitoring systems had not been used effectively to ensure improvements were identified and acted on quickly. The provider had also not consistently created a learning culture at the service which meant people's care did not always improve.
- The registered manager carried out a monthly 'Manager's Quality Audit'. The audits lacked detail and it was not always clear why some areas checked had not been satisfactory. There were shortfalls in recruitment practices at the service. For the most recent Manager's Quality Audit completed in September 2023 the recruitment section of the audit was blank. Previous audits had identified no concerns with recruitment.
- Other audits also lacked information about the measures needed to keep people safe and lacked detailed analysis to learn lessons. The pressure ulcer audit identified no improvement in one person's skin damage. There was also no information recorded to demonstrate there had been effective management oversight to ensure the person received adequate and timely care. The service completed medicines audits and whilst they had identified issues, it had not highlighted everything we found on inspection. For the issues identified by the service no action plan had been implemented to rectify the problems found. Some quality assurance audits were not available for October 2023.
- Communication of essential information during handovers to ensure staff understood their role needed improving. Handovers lacked detail with little information passed over to staff starting their shift. The written handover record was not fully accurate and/or not always detailed. A staff member told us, "Communication is a big thing, there's new residents. There's not an in-depth handover of their needs, we struggle sometimes." A relative said, "It's the communication. Some of the staff didn't know [family member] had been into hospital. It's the quality of their handover." The provider told us the handover was not representative of the usual standard of handover they expected, due to specific circumstances at the time of the inspection.
- Care records were not always accurate or fully completed. For example, information about one person's specific health and care requirements lacked enough information for staff to follow consistently. Fluid charts did not always demonstrate how people were supported to achieve their target fluid levels. For example, we could not see what escalation was taken when people did not achieve their daily fluid targets.
- The provider's improvement plan identified shortfalls in the service. Due to particular circumstances, most of these were still outstanding at the time of our inspection.

The failure to ensure an effective system was in place to monitor the quality and safety of the service was a

breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Due to recent concerns, the provider's management team were visible daily at the service. They were overseeing improvements designed to improve people's safety and well-being. The provider had also deployed additional staff whilst a review of the service took place.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Records did not demonstrate how the provider was meeting their responsibilities under the duty of candour. The duty of candour regulation tells providers they must be open and transparent with people about their care and treatment, as well as with people acting on their behalf. It sets out some specific things providers must do when something goes wrong with someone's care or treatment, including telling them what has happened, giving support, giving truthful information and apologising.

The failure to ensure the duty of candour policy was being followed was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider did not always have effective systems to provide person-centred care that achieved good outcomes for people. The service relied on agency staff to operate, some of these agency staff lacked an in-depth knowledge of people's needs.
● Staff spoke positively about the people they supported. They told us the care at the home was good enough for their family or friends. Three staff had been nominated for an "Angel award" in recognition for their outstanding contributions to the local community.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, relatives and staff had opportunities to provide feedback about the service, such as attending meetings.
● Whilst the provider had a communication system in place; the sharing of information was not always effective. One person and their family did not feel they had been involved or listened to until senior managers had become involved in the person's care at the time of the inspection.

Working in partnership with others
● The provider worked in partnership with others. The management team were engaging with external stakeholders to improve the service following some recent concerns.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a failure to ensure an effective system was in place to support people and their relatives to be involved in their care. Regulation 9(3)(c)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 ensure safeguarding allegations were appropriately managed and monitored. Regulation 13(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was a failure to ensure records demonstrated how complaints and concerns were responded to. Regulation 16 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour There was a failure to to ensure records

demonstrated how you were meeting the duty of candour requirements.

Regulation 20 (2)(3)(4)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	There was a failure to ensure new staff were recruited safely. Regulation 19(1)(2)(a)(b)(c).

The enforcement action we took:

We issued a warning notice to the provider.