Akari Care Limited

Princes Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 13 December 2016 and we returned on 14 December 2016 to complete the inspection. We visited the service again on 19 December to provide in-depth feedback to the home's care manager and a representative from the provider organisation. We previously inspected the service in February 2016 where we identified on-going breaches of the regulations which related to medicine management and governance. We also made recommendations around staffing levels and care plan reviews. There is a history of non-compliance with health and social care regulations at this service.

Princes Court is a residential care home situated in the Royal Quays area of North Shields. It provides accommodation, personal and nursing care for up to 75 adults with physical and mental health related conditions. At the time of our inspection 51 people lived at the home or were staying on a short term respite basis.

The person in charge of the day to day running of the service was known as the 'care manager'. They had been employed by the provider for several months. They were awaiting the outcome of their application and assessment by the Care Quality Commission (CQC) to become the registered manager of the service. A registered manager is a person who has registered with the CQC 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.

The governance of the service had not been thorough and effective. Internal audits and monitoring of the service had taken place however this had still not been robust enough to identify the issues we highlighted during our inspection. A new operations director had drafted a service improvement plan and reviewed it weekly. Following our inspection, the management team sent us an immediate action plan to address the shortfalls throughout the service.

We examined eight individual care records thoroughly and found that all of them contained inaccuracies or incomplete forms and some documentation held within the records were not always signed and dated. Improvements had been made with updating support plans to make them more detailed and person-centred. We saw 'service user profiles' were completed with personal information about life history, interests, hobbies and preferences.

Record keeping was poor in aspects of the service such as food and fluid monitoring, weight charts and positional change records which caused us concern and we asked the care manager to address this immediately. Individual risks which people faced in their daily lives were identified and control measures were in place to reduce the possibility of people coming to harm although these had not always been completed accurately or in a timely manner.

People who required nutrition and hydration support or were unable to swallow food and/or medicine due to the risk of choking where not always supported in the most effective way. Inadequate record keeping meant we were unable to ascertain if people's needs in this area were met in the safest possible way.

During the inspection some relatives brought concerns to our attention which we immediately raised with the care manager. There had been three previous incidents of a safeguarding nature which had been investigated by the local authority safeguarding team since our last inspection. Two of which were upheld and one was still on-going. The provider was working with other external agencies such as the Clinical Commissioning Group (CCG) to improve the service it provided.

The complaints policy and procedure in place was dated 2012 and the care manager told us this was the most up to date version they had. We reviewed the information kept in the complaints file and found that the care manager had not used the provider's complaints form and complaints register in line with company policy. This meant some complaints were not thoroughly recorded, handled and tracked in the way the provider would expect them to be. Complaints which had been made to the service and directly to the provider in the past had not always been recorded and responded to appropriately and satisfactory outcomes had not been received by some complainants.

We looked at how the service managed medicines. We found a small number of medicines were out of stock which meant some people had not received the care they required. There was an up to date medicines policy in place; the service now used an electronic monitoring system for managing medicines throughout the home and we found no issues with storage, administration or disposal.

A robust induction programme such as the 'care certificate' had not been implemented at the service and because of this; four new staff had not had their competency assessed against the minimum standards which are expected. Formal 'on-the-job' competency checks of experienced staff were not conducted. Training which the provider deemed mandatory had not always been refreshed in line with the targets they had set themselves. Appraisals had not been carried out for some time. This meant the provider could not assure themselves that staff were competent in their role or that they were formally supported to develop their skills and knowledge. Staff continued to be recruited in line with safe working practice.

We noted five occasions when staff did not give their support to people in the most dignified way. We have made a recommendation about this. At other times, staff displayed kind, caring and friendly attitudes. People we spoke with told us staff were nice and polite to them and relatives echoed this. People appeared to have a good relationship with the staff and it was apparent they all knew each other well. On the whole, care workers treated people with dignity and respect whilst assisting with personal care and we saw discreet interactions took place with people who required support to eat their meals.

The Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. In England, the local authority authorises applications to deprive people of their liberty. We found the provider was complying with their legal requirements with regards to DoLS, although decisions made in people's best interests were not always appropriately taken or correctly recorded.

The service offered people choices at mealtimes. The food appeared appetising and was healthy, hearty and well balanced. People had a choice of two hot meals and two desserts. Alternative options were available

for people who didn't want what was offered. Special diets were catered for, such as vegetarian, diabetic and soft diets. Catering staff were familiar with people's dietary requirements. We found that mealtimes provided added stimulation and socialisation.

Most people we spoke with during the inspection told us they felt safe living at Princes Court and most relatives confirmed this feeling. Staff were trained in the safeguarding of vulnerable adults and they were able to demonstrate their awareness with regards to protecting people from abuse and their responsibilities if they suspected wrong-doing. Policies, procedures and systems were in place to support staff with the operation of the service but these we were not always up to date and in line with current guidance.

Accidents and incidents were recorded, investigated and monitored. Analysis of these had been completed up to date to identify types, places and times of events to monitor trends. The care manager had reported these events to external bodies as required. The provider also monitored and analysed this information to track trends throughout the organisation.

People and relatives told us they generally felt there was enough staff employed at the service and staff responded to them when called upon. We heard some comments about staff shortages and delays at times. There were mixed opinions amongst the staff team about staffing levels although most staff told us they did not feel hurried in their duties and felt they were able to meet people's needs. Other staff felt there was not enough time to complete the daily documentation appropriately.

Routine safety and maintenance checks were carried out around the premises. People had personal emergency evacuation plans in place and tests were routinely carried out on fire fighting equipment. Other equipment and utilities were regularly checked and serviced by professional contractors. The premises were clean and tidy. The home had been decorated recently and this was on-going in one unit which caused a strong, unpleasant paint odour. Doors and handrails were painted in a contrasting colour to the walls and flooring to assist people with a dementia related condition to orientate themselves.

There were two diversional therapist's employed at the service which meant there was ample activity provision available on weekdays. There was no cover for weekends. We saw information was on display about forthcoming events and activities and we observed people engaging in a variety of activities which were meaningful and interesting to them. We reviewed records of one to one support given to people and saw there was access to outdoor space and trips into the community.

The provider had recently made changes throughout the senior management team. There were new company directors in post who have introduced centralised teams throughout the organisation with regards to quality, human resources and governance for example. This meant they would no longer use an external healthcare management support company to run the business. New specific policies and procedures had been drafted and the provider intended to cascade these to services imminently once they were approved by the new company directors. This would provide managers and staff with current guidance in line with recognised best practice.

Staff told us they were hopeful about the new leadership of the service. We heard a lot of positive comments from people, relatives and staff about improvements made at the service, better morale and team work amongst the staff. Staff meetings had taken place with each department and staff told us they felt able to approach the care manager and new senior managers whenever necessary.

We have identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

There continued to be concerns around the management of medicines. Other aspects of the service were unsafe, such as the arrangements to administer nutrition through a PEG feeding tube.

Risks were not always documented accurately and in a timely manner.

Incidents of a safeguarding nature had been upheld following investigation by the local authority.

Staff recruitment remained safe and there were sufficient numbers of staff on duty.

The premises were clean and well maintained.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not receive a thorough induction which formally measured their competency. Training was not up to date and appraisals not been carried out to support the staff in their role.

The monitoring of people's health and wellbeing was not effective due to poor record keeping.

The provider worked within the principals of the MCA with regards to DoLS, however, decisions made in people's best interests were not always taken appropriately.

Consent was sought from people although records did not always reflect this.

Is the service caring?

Requires Improvement

The service was not always caring.

We witnessed several undignified and disrespectful situations

which involved staff and people who used the service.

People and their relatives told us staff were nice, polite and friendly. Staff knew people well and provided support in line with their wishes and preferences.

Information, advice and guidance was provided to people for other services which would benefit them.

The service had received some very positive comments about the end of life care they delivered.

Is the service responsive?

Requires Improvement

The service was not responsive.

Complaints were not handled in line with company policy. Records showed complaints and constructive feedback was not always received, recorded, addressed and responded to appropriately.

Care records were person-centred and contained personalised details, however records we reviewed contained inaccuracies, were incomplete or had signatures and dates omitted. Care plans were not drafted in a timely manner in order to respond to the needs of people admitted in an emergency.

There was a wide variety of activities on offer and people enjoyed, one to one and group events, including day trips.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no registered manager in post. A care manager took charge on a daily basis.

We identified on-going concerns which related to the governance of the service.

Audits and checks of the service to monitor quality and safety were not robust enough.

Although the provider sought the views of people and their supporters, a system was not in place to communicate the results or any action taken.

Overall, people, relatives and staff spoke highly of the care manager and the new leadership of the service.

Princes 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 the 13 and 14 December 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor and an expert-by-experience. A specialist advisor is a person employed by the Care Quality Commission to support inspectors during an inspection; they have specialist knowledge in a certain area. The specialist advisor on this team was a qualified nurse with expertise in nutrition and hydration. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all of the information we held about Princes Court, including any statutory notifications that the provider had sent us and any safeguarding and whistle blowing information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We had not asked for a Provider Information Return (PIR) to be completed on this occasion. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we returned to the service sooner than planned in response to some concerning information which we had received.

We received information of concern from three relatives of people who had previously used the service. We liaised with North Tyneside Council's contracts monitoring team and adult safeguarding team and North Tyneside Clinical Commission Group (CCG) to share information and use the information they held to inform the planning of our inspection. Healthwatch (North Tyneside) also informed us of information they had received about the service. Healthwatch are a consumer champion in health and care. They ensure the voice of the consumer is heard by those who commission, deliver and regulate health and care services.

During the inspection we spoke with seven people who used the service and nine relatives. We spoke with 18 members of staff, which included the care manager, four nurses, senior care workers, care workers, the housekeeper, a diversional therapist and the cook. Representatives from the provider organisation also attended part of the inspection and we were able to speak with them about compliance, leadership and governance. We reviewed a range of care records and the records which are kept regarding the management of the service. This included looking at eight people's care records in depth and reviewing others. We also looked at five staff recruitment, training and development records.

Additionally we reviewed complaints and other records of three people who no longer used the service but had done so since our last inspection.

Requires Improvement

Is the service safe?

Our findings

At our previous two inspections of this service we identified a breach of Regulation 12 which included issues around medicine management. Although improvements had been made to address these issues, separate concerns were identified at this inspection which meant medicines were still not entirely managed properly.

Through observing the medicine administration rounds, reviewing records and speaking with relatives we discovered some medicines were out of stock which meant people had not received the treatment they required. For example, one person's topical medicine had ran out and further stocks had not been ordered in time. Topical medicines are described as cream and ointments applied to the skin. A nurse subsequently placed an order but a delay from the pharmacy which was not followed up by staff in a timely manner meant the person did not receive appropriate treatment for three days. Their relatives told us this had caused pain and discomfort. They said, "It's terrible – it should not have got to that state – there is no excuse."

Another relative told us, their relation was prescribed nutritional supplement drinks. They suspected bottles were being left open for longer than the recommended 12 hours and felt it was necessary to mark one bottle in order to confirm this. They said, "I told staff about it numerous times and action was not taken." They told us that three days later they found the same bottle still open in their relative's room. These drinks should be discarded after 12 hours if not refrigerated as the ingredients will begin to decompose and become inedible, which may have a detrimental effect on a person's health and well-being if ingested. We were told by a relative that the supplements had been given to the person following discharge from hospital and although labelled and properly prescribed, the staff had not added these to the medicine administration record on the person's return to the home. This meant some staff may not have been aware of their existence. They were also not stored correctly. Nutritional supplements should be kept cool to ensure their effectiveness remains. We found these supplements were stored in the person's wardrobe and some staff were aware of this.

We also found that procedures to administer nutrition and medicines though a PEG (Percutaneous Endoscopic Gastrostomy) tube were not followed correctly. PEG feeding allows nutrition, fluids and/or medicines to be put directly into the stomach, bypassing the mouth using a flexible tube which is inserted into the stomach. For example, one person had received daytime nutrition overnight which was against the recommendations written in the records from a dietician. This was unsafe for a person with a reduced swallow as it carried high risk of aspiration, can cause chest infections and in extreme cases, death if the person is not positioned correctly or moves whilst asleep. Another person was not sitting in the correct position (a 30°- 45° angle) to receive the nutrition. We heard the machine which pumped the nutrition through the tube alarmed for over an hour before staff responded to it. Instructions had not been written in care plans about a safe angle for people to receive nutrition or medicines and records were not made by staff to monitor the angle people were positioned in. We asked the care manager and nurses to address this immediately, which they did.

Since our last inspection, three separate incidents of a safeguarding nature had been investigated by the

local authority. Professionals from a multi-disciplinary team, including local authority and NHS adults safeguarding teams, commissioners and social workers had agreed that two of these incidents were upheld. The third was still on-going. This meant having looked at the evidence presented to them, which included complaints, investigation reports, witness statements and records it was apparent that people had received care and treatment which was not at the standard expected and this had caused a detrimental effect of their health and welfare. It was also identified that records used to evidence care delivered required improvement. Adult protection plans had been implemented and the service continued to work with these agencies to improve their practice. During our inspection we found that record keeping especially with regards to the daily monitoring of care such as food and fluid charts and positional changes charts were not satisfactory and therefore the service was unable to always evidence that safe care and treatment had been delivered.

Although individual risks which people faced on a daily basis were assessed and planned for, we found examples when these was not always completed accurately or in a timely manner. For example, one person who was admitted to the home in an emergency due to extreme weight loss and behaviour related to a dementia diagnosis, did not have care plans fully completed four days after admission. The care manager told us she would expect nursing staff to complete these within 48hours especially if there were risks. Due to this delay, care staff had not monitored food and fluid intake for the first four days. Additionally, we found discrepancies within this person's weight records. For example, on 9 December weight was recorded as 37.1kg and on 12 December an entry of 30.9kg was recorded in the care plan. As this was extremely concerning, indicating a loss of 6.2kg in three days, we asked the care manager and nurse to investigate. It became apparent that the weights were not a true reflection; the person weighed 36.7kg on the day of inspection. The food and fluid charts for this person were not comprehensive and did not present a true reflection of nutritional intake.

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

All staff had undertaken training to make them aware of how to safeguard vulnerable adults from abuse. Through discussion they were able to demonstrate to us that they were aware of their responsibilities and could describe the actions they would take if they suspected harm or abuse had or may occur. They told us, "I'd report it to the nurse or manager" and "Report it – go to a senior or the manager." The service followed the local authority safeguarding procedure and had fully cooperated in investigation meetings. Policies and procedures were in place to assist staff with the running of the service and provide support and guidance, however most policies were out of date.

We reviewed 27 recorded accidents and incidents from November 2016, we saw these were investigated and monitored. Analysis of these had been carried out to identify types, severity, injuries, places and times of events in order to monitor trends. Accident forms and witness statements had been completed by staff involved. The care manager had reported these events to external bodies as necessary which included the local authority safeguarding team and CQC.

At our last inspection we made a recommendation that the service ensured the staffing levels were maintained. We reviewed the previous four weeks of staff rotas and saw that shifts were scheduled in advance with a set amount of staff according to the care manager's dependency assessment. On the day of inspection, due to sickness absences the set amount of staff were not on duty when we arrived, however this did not appear to have a major impact on the service.

Most people and relatives told us they felt safe in the home and gave examples around the use of

equipment, staffing levels and response to call bells. A relative said, "I think they do keep her safe, they watch her, they reassure her and there's always two staff." Most relatives told us there was enough staff available and staff were responsive. There were some comments about staff shortages at weekends and delays at night. The staff team had a mixed opinion about staffing levels although most staff did not feel hurried and felt they were able to meet people's needs. Some staff told us they found it difficult to complete daily monitoring tools accurately or thoroughly such as food and fluid charts due to the length of time it took them to get around to it. During the inspection, we discussed an alternative way of working which the care manager and care staff were happy to try in order to rectify this issue.

Staff recruitment remained safe. We reviewed five recruitment files of staff who had been employed since our last inspection and saw the appropriate checks were in place. Staff confirmed pre-employment checks had been carried out.

The premises continued to be looked after and well maintained. The environment was clean and tidy and routine safety checks were undertaken by the maintenance man. Tests and servicing on equipment and utilities was carried out by external professional contractors and we saw these were completed as scheduled. There were personal emergency evacuation plans in place for each person to ensure the safe evacuation of the building in the event of an emergency.

The domestic team was led by a housekeeper who we found to be highly motivated. The housekeeper took the lead for infection control and implemented new initiatives with her team of domestic and laundry staff which had contributed to them receiving an award for 'Best in North Tyneside' from the local NHS infection control nurse. The cleaning schedules were up to date, detailed, signed off and checked by the housekeeper. Elements of best practice were evidenced and responsibilities were delegated amongst the team for accountability.

Requires Improvement

Is the service effective?

Our findings

A relative told us, "This is supposed to be a nursing home; I don't know where the nursing is." Another said, "There is no consistency, one [staff] doesn't know what the other is doing."

Registered providers are expected to implement a robust induction programme such as the 'Care Certificate' for new staff employed after 1st April 2015. Whilst the Care Certificate is not mandatory, providers should be able to demonstrate that staff are competent in 15 minimum standards such as duty of care, dignity, person-centred care and communication. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. The care manager told us the Care Certificate had not yet been implemented in the service and there were no formal competency checks being undertaken of new or experienced staff. This demonstrated that the provider could not be assured that the service provided to people who lived at Princes Court was being delivered by staff who were competent in their role. Following the inspection, the provider sent us information which confirmed there were four members of staff who should have commenced with the Care Certificate as per their induction policy and this had been subsequently actioned. They also told us formal competency checks of experienced staff would be conducted by senior staff with immediate effect.

In addition to this, training which was deemed mandatory by the provider was not entirely up to date. We reviewed the current training matrix which showed a number of staff were overdue refresher courses in topics such as safeguarding vulnerable adults, moving and handling people, mental capacity awareness and health and safety. This meant some staff may not have been up to date with current best practice, legislation and guidance. The care manager had some training sessions booked with internal and external training providers in order to meet the training requirements. A full list of all training sessions booked to meet their needs was sent to us by the provider following our inspection.

The care manager told us they had not carried out an appraisal of performance with any members of staff; however they planned to complete these in January 2017. They were also unable to provide us with any appraisals carried out by the previous registered manager. This showed that staff had not received an annual review of their performance against the company objectives or made a plan of how to achieve future goals.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All new employees had completed a two week company induction which covered operational activity, policies and procedures. They also shadowed an experienced member of staff during this time. A six month probationary period was in place and the care manager met with staff after three months to review this. We saw probationary review meetings and supervision sessions had been carried out with staff on a regular basis. The key areas covered included conduct, training, attendance and an action plan. These were conducted and signed off by a supervisor and reviewed by the care manager. We saw ad-hoc supervision

sessions were convened to record and monitor any minor conduct or performance related issues. Staff were supported to undertake qualifications in Health and Social Care and some staff had achieved these.

Staff told us they were happy with the care manager and most of them said they felt supported in their roles. Many gave practical examples of how the care managed had supported them. Staff confirmed their received supervision. A staff member said it had been "three or four months ago", another said it was "in the summer time." A staff member told us that although they had not received formal supervision they had lots of informal discussion. They told us, "[Care manager's] door is always open."

The care manager overseen departmental staff meetings to ensure staff effectively communicated information to each other. We observed a handover meeting which took place and we reviewed minutes from a variety of staff meetings. Care workers and nursing staff made daily notes to document the care and support provided to people. This enabled staff on opposite shifts to be aware of on-going issues and could continue to monitor circumstances as necessary. However as records were not always accurate and thorough, we found effective communication was not consistent throughout the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it is in their best interests to do so and when it is legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care records showed, and the care manager confirmed the majority of people living at the home were subjected to a DoLS. We reviewed the records regarding the application to the local authority and outcomes of these decisions. The provider had also notified the Care Quality Commission of these as they are legally required to do so. We saw evidence that decisions were made in people's best interests. However, the forms used to record these were not always completed and some were unsigned and undated. A multi-disciplinary team including external health and social care professionals should be consulted in this process. The records we reviewed showed the decisions had mostly been made between staff in the home and a relative. Staff had received training on the MCA and demonstrated an understanding of their responsibilities towards working within its principles.

The provider had consent forms in place to gain people or their supporters consent to the care and treatment they received. Although these forms were in the care records we reviewed, we found they were mostly unsigned and undated. We observed staff gained consent from people before they provided assistance.

We observed the service provided to people at mealtimes. We found the experience was positive. People could choose to come to the dining rooms or have their meal served in their room. Tables were pleasantly set with tablecloths, napkins and a hand decorated centrepiece which looked welcoming and homely. Soft Christmas music added to the friendly atmosphere. The provision of food and drinks was good and the meals looked appetising and well-balanced. People were given a choice of from two main meals and two desserts. People were offered extra portions. Catering staff were happy to prepare alternatives for people who didn't want what was on the menu. One person told us, "Anything you want, you can just ask." We saw the cook had prepared stewed apple and custard with no sugar for people with diabetes as an alternative to cake and ice-cream.

We saw care staff asked people if they would like to use an apron to protect their clothing and they chatted with people about the food. They also encouraged people to eat and in most cases, gave discreet support to people who needed assistance to eat their meal. People were given hot and cold drinks in various styled cups and beakers to meet their individual needs. High edge plates were in use to promote the independence of people who needed assistance.

Records kept to monitor the food and fluid intake for people at risk of malnutrition and/or dehydration required improvement in order for staff to provide effective care and support. We reviewed food and fluid charts and found that on many occasions these were brief and incomplete. Staff told us they did not always have the time to complete these charts with satisfactory details and sometimes records were not made until hours later which often meant they could not accurately remember what people had ate or drank. This meant that nutritional and hydration intake was not monitored appropriately which could, if repeated lead to unnecessary weight loss and dehydration. A new working practice was put into place and trialled from the day of inspection.

We carried out an observation in the kitchen area and spoke with the cook and kitchen assistants. Best practice guidelines were being followed in the kitchen. We saw separate preparation and storage areas were used for raw and cooked foods. The catering staff monitored the temperatures of equipment and checked the temperature of food before it was served. Refrigerators and freezers were well stocked, clean and tidy. Store cupboards had a selection of fresh fruit and vegetables together with dry ingredients for home baking and making meals from scratch. They told us they fortified food with extra calories to reduce the risk of malnutrition or weight loss. The cook had been given diet sheets which informed them of prescribed diets and preferences. They prepared pureed and mashed food for people as necessary. A relative told us, "It looks like they are slowly introducing food to teach him (their relation) to swallow." Another told us, "My [relative] has put some weight on since she got here."

Records showed and relatives told us, people had good access to external health and social professionals to support their general health and well-being. We saw visits from external professionals were recorded in people's care plans.

The decoration and design of the home was attractive and homely, however the strong odour of paint was not pleasant for people or visitors in one unit. The service incorporated elements of best practice dementia care by painting walls and doors in contrasting colours to help people orientate themselves. There was appropriate pictorial signage to assist people to recognise rooms. People's bedrooms were decorated and individually styled with personal items which were sentimental to them, including photographs and ornaments. Communal areas contained ornaments and items of interest to stimulate memories and encourage conversation. We saw these items interested people and they provided a distraction for people who were agitated or restless due to their condition.

Requires Improvement

Is the service caring?

Our findings

During our observations around the home we witnessed some negative interactions between staff and people who used the service; we also felt some of the situations we observed were not respectful. We reported these to the care manager and the provider who told us they would address our findings. For example, on two separate occasions we observed a care worker stood up to assist people to eat their meal, we saw two care workers use an inappropriate manoeuvre to assist a person from a wheelchair to a lounge chair and one person was left unattended in the lounge for a long period of time in an uncomfortable position with food debris on their clothing.

The training matrix showed that a course in dignity and respect was not provided to staff and in the absence of a robust induction programme these topics had not been specifically delivered to staff.

We recommend the provider ensures staff are trained and competent in ensuring peoples dignity and privacy needs are met and maintained.

Confidentiality was maintained during our inspection as staff spoke with us discreetly about sensitive issues; however we witnessed a conversation inappropriately held in an office with open doors between staff which could clearly be overheard in the corridor by people and visitors. We later received feedback from a relative who overheard this conversation. People's personal data and confidential records were stored securely in a designated office space.

Overall, the staff we spoke with displayed respect for people and described how they maintained privacy and dignity. They told us, "We always knock on the door before we go in" and "We close people's doors for privacy." Care workers we spoke with told us they covered people with towels when assisting with intimate personal care. We observed staff addressed people in a nice, friendly and polite manner. Staff respected people's wishes and preferences and considered people's different needs, such as ability to take medicines, mobilise and participate with certain activities.

People made positive comments to us, which included, "They (staff) are all lovely", "I couldn't wish for better", "Everything is perfect, the staff get better and better" and "I can't fault it". Relatives echoed these comments and added, "They're (staff) caring, without a doubt", "They (staff) seem very caring, helpful. They do their best" and "They're lovely, they treat her the way I do." The staff clearly knew the people they supported well. The service had received compliments and there were 'Thank you' cards on display.

Discussions with the care manager and staff revealed that some people who used the service had particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that people who used the service were discriminated against and no one told us anything to contradict this. Records showed positive plans were made to ensure people's needs were met in a way which reflected their individuality and identity.

There was information, advice and guidance on noticeboards around the home regarding aspects of the service such as 'resident and relative' meetings, newsletters, activities and events to inform people of relevant topics which may be of interest. People had been given a 'service users guide' upon admission which contained information about the service; what to expect, what services were offered and the local amenities. Other information which would benefit people was on display, such as local safeguarding contact details and leaflets on dementia, mental capacity, infection control and advocacy.

We asked the care manager if any person currently used advocacy services. One person had access to a formal advocate who we saw visited the person during the inspection. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld. We were told that the service could refer a person to an independent advocate from the local authority if people needed the support. Some people had family who acted on their behalf formally with legal arrangements' in place such as relatives acting as a lasting power of attorney for finances and health matters. We saw this was evidenced in care records.

There was a process in place to ask people about their end of life wishes, including advanced care planning, emergency healthcare wishes and resuscitation preferences. Some records showed people had declined to consider this part of their assessment and staff had reviewed this regularly. A care worker told us, "We talk to the families and are led by them, we leave it up to them and we're there to support them." We saw there were some very positive compliments had been left on an external website called carehome.co.uk by relatives which specifically related to recent end of life care provided to people at Princes Court. The website had summarised the scores given by people which resulted in a positive score of 9.1 out of 10.

Requires Improvement

Is the service responsive?

Our findings

We received information from three families who had made one or more complaints to the care manager and/or provider with regards to the service at Princes Court, which they felt had not been responded to appropriately or in line with the provider's complaints process. A relative told us about severe delays in receiving a response from the provider to their complaints or questions.

Before and during the inspection we checked the complaints records held at the home along with any care records, incident records and witness statements relevant to these three investigations. We found that the information provided to us was not detailed and contemporaneous. This meant the service did not have comprehensive evidence to allow them to thoroughly investigate and respond to the complaints. We also saw that an investigation report provided to the local authority safeguarding team had not been satisfactory and the care manager had been asked to undertake a more methodical approach and submit a further in-depth report, which they did and we reviewed this.

At the inspection we examined the complaints file which contained records from 2015-2016. We found that the care manager was not using the provider's 'complaint form' to record all verbal and written complaints as per the company policy. We also found that complaints were not always formally acknowledged with a standard letter which the provider had drafted. Copies of outcome letters were not always stored with the complaint information, so we were unable to see whether the response given to complainants detailed in full, an explanation, an apology if necessary and any action which was taken to improve the service. Due to the lack of recording we were unable to tell if complainants had been satisfied with the response, if the response was given within the expected timescales or if the service had been reviewed following any improvement or development. There was no evidence within the complaints records to suggest that information about improvements made to the service following feedback had been shared with people who used the service, their supporters or staff who worked at the home.

The care manager told us that the complaints policy dated 2012 was the most up to date version they had been given. We saw this policy explained the use of the 'complaint form' and a 'complaints' register. The care manager told us they had not used either of these documents to record information about complaints. However some historical complaints were sporadically recorded on both of these forms prior to the care manager being in post. The complaints register should be used to briefly record complaints over time in order for the care manager and the provider to monitor complaints, look for trends and identify areas of risk to address.

At the inspection, a relative told us they had informed care workers "a number of times" about an issue. We saw that one care worker had written an entry in the relative communication log, which read, "Daughter has concerns about food and fluid." We asked the care manager about this and she was not aware of the issue. She told us, "This is new to me; no-one has come to me about this. If we can resolve this for them, then we absolutely will do that."

We considered that despite an established system being in place to identify, receive, record, handle and

respond to complaints made about the service; this had not been operated effectively in order to respond appropriately to complainants.

These issues were a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the action plan submitted to us by the new directors described the process which would be immediately implemented. This included reviewing all historical complaints and ensuring they were logged into a complaints form and added to a complaints register. Any outstanding actions were to be reviewed and signed off as completed by the regional manager and in future, all complaints would be sent to the regional manager and quality manager to enable progress to be monitored.

At our previous inspection we made a recommendation that care plans were more regularly reviewed, especially for people whose needs often fluctuated. We looked at four care records of people who currently lived at the home. Care plans were in place to address all aspects of daily living such as, communication, hygiene, nutrition, sleep, mobility, skin integrity and medicines. They described the support staff should give to achieve a goal or positive outcome. We saw these were reviewed and evaluated on a monthly basis to ensure the most current care needs were reflected.

The care records contained person-centred information and were personalised with people's likes, dislikes and preferences. This enabled staff to get to know people well. The records contained assessments of safety, dependency, continence and capacity for example. However they were not always fully completed, signed or dated. In one care record we found seven documents which were not dated, including the 'service user' profile, daily activities assessment, a consent to restrain form, an agreement to the planned care, a dementia care plan and an hourly observation chart which had been put in place to monitor the person after an incident. A care plan audit which had been completed to check this information had not picked up on these omissions and was also undated.

We looked at the care record of a person who had been placed at the home for respite in an emergency situation. The person had been at the home for six days on the second day of our inspection. As reported in the safe section of this report, basic assessments had been completed to record the risks the person faced but it had taken senior staff four days to draft care plans. This meant that care staff had not commenced appropriate daily monitoring of the person's health and well-being in order to be responsive to any changes. We found that some care plans were still incomplete. Despite the daily notes describing two visits from a relative and one visit from a social worker, personalised information regarding family history, likes, dislikes and preferences had not been gathered and recorded in the care records in order for the staff to have an understanding of the person and give them insight to the person's life in order to develop a relationship, build trust and confidence.

The service employed two diversional therapists who were responsible for the coordination of activities and events. They both worked weekdays with no cover at weekends. Care staff supported activities when time permitted but this was not consistent throughout the home. A care worker told us they played dominoes with people, put music on or DVD's. Some care workers told us they would like more time to read peoples' social care plans to find out more about people. Relatives also felt care staff did not have time to spend with people. One said, "They don't have a lot of time spare, they pop their heads in."

We reviewed the information held by the diversional therapists and saw they had planned and organised a wide variety of activities which were interesting and meaningful to people such as arts and crafts, reminiscence sessions and entertainment. They maintained a noticeboard and the weekly activities

programme was on display along with upcoming special events. We saw photographs of people engaging in recent activities such as a Halloween party, a Doris Day tribute singer, a visit from the discovery zoo and small petting ponies. A diversional therapist told us a person had commented that joining in an activity had "made his day", which they were proud of.

As well as group activities, people had a small amount of one-to-one time with a diversional therapist tailored around their individual choices. This included a one to one conversation, playing dominoes or looking through photographs. Small groups of people were escorted out into the community and they visited places such as the local shopping centre and fish quay. Relatives we spoke with said, "She's [their relation] enjoying herself in the lounge" and "When she's [their relation] with people she is so much better."

The diversional therapist we spoke with had not had any formal training in their role, but had attended courses on care related topics such as mental capacity awareness and dementia training. They had worked in the home for many years in a variety of other roles. They knew people very well and told us of how they used their knowledge to support people. For example, they explained one person used to be a cookery teacher and they helped out with activities by demonstrating techniques to others in baking sessions. Another person who had worked at the local shipyard liked to read old newspapers and look at photographs of the local area. There were plans in place to purchase a table tennis table as some people said they used to enjoy playing.

Requires Improvement

Is the service well-led?

Our findings

There is a history of non-compliance with health and social care regulations at this service. In particular at our last inspection, we identified two on-going breaches which related to the safety and governance of the service. At this inspection we identified issues which added to our concerns about the service and found that the service continued to fall below expectations in order to meet compliance requirements.

At this inspection we found record keeping still required significant improvement. We examined a large sample of care monitoring records and found that they were not always legible, descriptive, accurate and completed. In particular, records kept to monitor people's daily health and well-being, such as food and fluid intake charts, weight charts and positional change charts, contained gaps and were not always completed or precise. During our review of complaints prior to the inspection, we were told some charts had been misplaced, some of which were subsequently located and forwarded to us. Other records such as complaints and historic appraisals, which we asked for during this inspection were not provided as they could not be located.

The management team had not ensured that a robust induction programme was implemented at the home and staff competencies were not being formally assessed or monitored by senior staff or the care manager. Only 60% of staff training was up to date, however this had risen from 42%. The provider had set a target of 80% compliance for this service. Appraisal of staff's performance had not been carried out for some time. We found issues with medicines being out of stock and complaints not managed in line with company policy.

Not all policies and procedures were up to date. There was no evidence to suggest staff had reviewed these on a regular basis and understood them. This meant that the provider had not ensured staff were formally made aware of nationally recognised guidance, best practice and changes to quality standards which could affect their working practices. The new operations director told us improved policies and procedures had been drafted and were awaiting approval from the senior management team. Once approved, they would be shared with the care manager to implement within the service.

The care manager carried out a daily walk-around of the home and completed weekly and monthly checks on the safety and quality of the service. They reported statistics through an electronic system which fed information directly to the regional manager and the provider. Electronic systems were set up to analyse audits of the governance of the home including feedback. The provider kept an overview of the service and made regular quality assurance visits to check on the service. The care manager completed reports to monitor key performance indicators (KPI's) such as, weight losses, pressure damage, infections and hospital admissions.

Although these established systems and processes were in place, they had not been performed effectively enough in order to identify and address the concerns we raised about the service. For example, a daily and weekly report had not been monitored in order to identify medicines which were out of stock. The care manager was unable to provide us with a current copy of this report. This meant that the management team had not wholly identified the potential risks to the health and safety of people who used the service, ensured

correct documentation was in place or took suitable action to mitigate, reduce or remove risks. In turn they had failed to ensure compliance with the regulations.

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

There was no registered manager in post. A care manager was employed, who took charge and managed the service on a daily basis. They had been in this role since August 2016 and had supported the previous registered manager in a peripatetic role following our last inspection. Following the resignation of the previous registered manager, the care manager had applied to the CQC to become the registered manager of the service. They had recently attended the 'fit person's' interview and were awaiting the outcome. The 'fit person's' interview is undertaken by CQC registration inspectors to assess a candidates suitability for the role.

Prior to our inspection we checked our records to ascertain whether statutory notifications were being submitted and we found they were. The care manager had sent regular notifications to us about applications for DoLS and notifications of deaths or other incidents which had occurred at the home on behalf of the provider, who is legally responsible for this.

The provider had sought the views of people who used the service and their supporters. However, all but one relative we spoke with could not recall being asked for feedback. One relative told us they could remember completing a questionnaire. The care manager told us the head office conducted these surveys and the results were sent back to them to collate. We asked to see a copy of the latest results but could not be provided with them. This meant that an effective system was not in place to communicate the results of a review and any actions needed, with the people who used the service.

Most relatives we spoke with were not aware of the 'resident and relative' meetings; however we did review the minutes from the last meeting held in October, the contents of which featured heavily around activities and upcoming events.

Staff meetings took place throughout each department within the home. We reviewed the minutes of meetings held with clinical nursing staff, care staff, activities staff and the cook. Some people who used the service had attended the meeting with the cook to discuss their preferences around the menu. Staff had the opportunity to raise any issues which they faced and the care managed regularly talked about themes such as safeguarding, infection control and health and safety. We did not see any evidence of learning outcomes from complaints or incidents shared amongst the teams to drive through improvements within the service.

Visitors to the home commented positively on the atmosphere. One said, "It's got a lovely atmosphere, staff are relaxed, I can't fault them." Another said, "I would have no hesitation in recommending people to this home." Other positive comments includes, "It's well run – from what I have seen", "I think it's very nice, clean and comfortable" and "It's calm and relaxed." A relative described the care manager as, "Very pleasant and very efficient."

Staff also made some positive about the leadership of the home and felt supported by the care manager. Comments included, "It's lovely now, a much better atmosphere. If you have a problem you can go to [care manager] and she tries to help. She wouldn't just leave it", "[Care manager] is trying her best; she's lovely, lifted everybody's morale. She wants everything to be right and spot on" and "[Care manager] is very approachable, very fair. She will listen to what you've got to say, if there's a difficult situation she will get involved, she's pulled this place together."

The provider had recently appointed new company directors who had vast experience between them in the health and social care industry. They had already introduced centralised teams throughout the organisation and restructured it to include national roles in quality, human resources and governance for example. This meant they would no longer use the external healthcare management support company which had previously supported the provider to manage the business. The new directors had drafted a service improvement plan prior to our inspection and were monitoring the progress of the service on a weekly basis.

Throughout the inspection and afterwards during feedback, the management team were receptive of the evidence we presented to them. Following the inspection, the provider has been proactive in their response to our findings, has supplied additional evidence as requested and submitted a detailed action plan which we will monitor on a weekly basis.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in the safest way. Risks were not always identified and mitigated against in a timely manner. Medicines continued to be managed in appropriately. Regulation 12 (1) (2)(a)(b)(c)(e)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not managed in line with company policy. Complaints and feedback was not received, recorded, handled and responded to in a satisfactory or timely manner. Despite an established procedure in place, the registered provider did not ensure it was operated effectively. Regulation 16 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to ensure compliance with the regulations. Audits and checks on the service were not robust and had continued to fail to identify and address concerns and issues. Records were not accurate, complete and

	contemporaneous in respect of each service user. Regulation 17 (1) (2) (a)(b)(c)(d)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training and appraisal to enable them to carry out their duties. Staff competency was not being assessed or measured in line with recognised national minimum standards. Regulation 18 (1)(2)(a)