Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Princess Lodge Limited

11 High Street, Princes End, Tipton, DY4 9HU

Tel: 01215571176

Date of Inspection: 16 December 2013

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Princess Lodge Limited
Registered Managers	Mr. Frank Brown Mrs. Jayne Elizabeth Whitehouse
Overview of the service	Princess Lodge is registered to provide accommodation and nursing care to a maximum of 36 people. People living there have a range of conditions related to old age which may include dementia.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Princess Lodge Limited had taken action to meet the following essential standards:

- Assessing and monitoring the quality of service provision

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 16 December 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

We inspected Princess Lodge Limited to check if improvements had been made following our last inspection in October 2013, when we served the provider a warning notice for regulation 10 and told them that they were required to become compliant with the regulation by 13 December 2013. This was because we found that effective systems were not in place to assess and monitor the quality of service that people received or ensure that the provider identified monitored and managed risks. We judged at the time that this had a major impact on people who lived at the home.The registered managers as detailed on this report no longer worked in the home.

At the time of this inspection there were 27 people who lived at the home, we spoke with three people and four of their relatives. We looked at two people's care records and medication administration records. We also spoke with the general manager, the deputy manager and four members of staff.

Our conversation with people and their relatives demonstrated that they were generally pleased with the staff, this was mostly because they felt staff were doing as much as they could reasonably do. One person told us, "Staff do their best". A relative told us, "Staff do try". However, it was evident that there were still areas for improvement. One person told us, "You have to wait for everything". A relative told us, "Who the manager is a bit of a mystery, if something crops up we are not sure who to go to". We found that although the provider had implemented some quality monitoring systems, the improvements required to meet the warning notice had not been fully addressed.

You can see our judgements on the front page of this report.

What we have told the provider to do

Where we have identified a breach of a regulation during inspection which is more serious,

we will make sure action is taken. We will report on this when it is complete.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider had no effective system to regularly assess and monitor the quality of service that people receive.

The provider had no effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

We looked for evidence to see if the provider had met all of the requirements of the waning notice we served on 13 November 2013. We saw that provider had made some improvements to monitor the quality of the service provided. This included a 'Complete server' audit which covered a range of areas such as health and safety, food and nutrition and quality assurance. This meant that the quality of the service provided was being monitored. When we asked people and their relatives about their views of the service provided their responses included comments such as, "The staff are very helpful" and, "I am happy". One relative said, "Staff are very good". This showed that people and their relatives were overall happy with the staff working at the home.

At our last inspection in October 2013, no surveys were offered to people or their relatives. During this inspection we saw that recent surveys were provided to people and their relatives to allow them to give feedback on the service. We saw there were only four completed and returned surveys, three were from friends/relatives and one was from a person who lived at the home. The general manager told us once further surveys were returned the feedback would be analysed. This demonstrated that there was a system in place to seek the views of people and their relatives in order to improve the service.

At our last inspection we found that the provider had not forwarded a statutory notification for harm to a person or allegation of abuse. We also saw that there was no overall system to record and track safeguarding referrals. During this inspection, the deputy manager told us that there had been no safeguarding incidents at the home to warrant a statutory

notification to us, the Care Quality Commission (CQC). The general manager told us that if a safeguarding incident occurred, they would then put a system in place and they were seeking support from the local safeguarding team to develop a system. As this was a requirement of the warning notice, this meant that that the provider had not fully complied with the warning notice. We also confirmed with the general manager that since our last inspection in October 2013, there had been three incidents that would have required the provider to send CQC statutory notifications however, no notifications were sent. This showed that some staff again had not taken the action to inform CQC of accidents or incidents that required statutory notifications to us. This meant that that the provider had not fully complied with the requirements of the warning notice.

At our last inspection we saw no evidence that meetings took place for people who lived at the home or their relatives. During this inspection all of the people we spoke with and their relatives told us that meetings did not happen. This was also confirmed by the general manager. One person told us, "There is not much to do other than watch television". A relative told us, "There is not much activities". This showed that people and their relatives had feedback to give. Some of the staff spoken with told us that they did not always have time to do meaningful activities, we saw no activities taking place on the day of our inspection. The general manager told us of plans to increase activities at the home and that a meeting for people who lived at the home was scheduled for 14 January 2014, this was because their newly appointed manager would be in post. However, the absence of any meetings meant that there was no formal system in place for people and their relatives to have the opportunity to regularly comment on their experiences of the service and how they would like the service to be delivered. This meant that that the provider had not fully complied with the requirements of the warning notice.

At our last inspection in October 2013, we identified that the provider had a complaints policy however, there was no complaints information available in an accessible format for people. The provider was also unable to show the system used for recording and reviewing complaints. During this inspection we saw that there was a complaints log which showed the nature of the complaint, the outcome and action taken. We saw that a recent complaint made had been resolved accordingly. This meant that themes and trends from complaints could be identified and acted on to improve the service. However, we saw and the general manger confirmed that there was no information on display at the home or available to people and their relatives on raising a complaint. One relative told us, "It would be nice to know who to go to". This meant that the complaints procedure may not be accessible to people and systems were not in place for the provider to take account of complaints and comments to improve the service. The general manager told us that this information would be made available immediately. This meant that that the provider had not fully complied with the requirements of the warning notice.

At our last inspection we found the recruitment system was not effective in ensuring only suitable people were employed. This was because necessary checks were not competed. During this inspection we looked at the recruitment records of two staff members. We saw that a 'recruitment audit' was now in place to ensure all checks were completed. In the two staff records that we looked at we saw that appropriate checks were completed. However, we saw that two members of staff had a disclosure on their Criminal Records Bureau check (CRB). We saw that the risk assessments in place for both staff were not robust. This was because the risk assessments did not include any details of the level of risk and how any risks would be minimised. This showed that there was a lack of effective assessment and management of risks to the health, safety and welfare of people who used the service. This meant that that the provider had not fully complied with the

requirements of the warning notice.

We saw that there was a now a system for recording accidents and incidents. We looked at the care records for one person and saw that they had a recent accident and this was recorded in the accident/incident folder. However, we also saw in their care records that the following day a member of staff identified a change in the person's condition which meant they required medical attention. It was not clear from the care records, if this was a result of the previous day's accident or a new accident or incident had occurred. There was no record of this in the accident/incident folder. This showed that the system still did not fully reflect all accidents and incidents that had occurred at the home and therefore may not identify themes and trends. This meant that that the provider had not fully complied with the requirements of the warning notice.

We saw evidence that there were now regular medication audits taking place. However, we looked at the medication administration charts (MAR) for two people and saw there were gaps and inconsistencies. In one person's MAR chart we saw there was a missing signature. In another person's MAR chart we saw there were missing dates, and for one medication we saw that the amount signed for on the MAR chart did not match the amount remaining, there was more medication left than what was signed by staff on the MAR chart. This meant that medication audit had not been fully effective in improving medication managements systems.

We saw evidence that an infection prevention and control audit was now taking place. However, we saw a member of staff undertaking cleaning duties without wearing an apron. This meant that improvements were still required in infection prevention and control procedures.

Following our last inspection we met with the provider on 13 November 2013, and they agreed on a voluntarily basis to not accept any new admissions to the home. At the time of the meeting there were 24 people who lived at the home. This was to allow the home to focus on the necessary improvements and implement changes effectively. However, during this inspection and evidence that we obtained showed that since the date of this meeting there were 3 new admissions to the home, this meant there were now 27 people who lived at the home. The general manager told us that their understanding of this arrangement was that the maximum number of people that could live at the home at any one time was 27. However, this told us that the voluntary arrangement with the provider required reviewing to ensure clarity.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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