Akari Care Limited

Piper Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Piper Court is a residential care home providing personal and nursing care to a maximum of 60 people. 43 people were using the service at the time of the inspection. Piper Court is purpose built and accommodation is spread across three separate wings, each of which has adapted facilities. Some people are living with dementia and one of the wings provides care to people living with mental health conditions.

People's experience of using this service and what we found
People we spoke with told us that they felt safe living in the home. However, we identified concerns in relation to people's safety and the leadership of the home.

Staff did not follow infection prevention and control procedures despite evidence which showed they had completed training in this area. PPE was not always worn correctly, and some staff were travelling to and from work in their uniforms. Medicines were not being managed safely. There were no fire drills taking place and regular health and safety checks had not been done since the beginning of 2021. All staff we spoke with had concerns about safe staffing levels. Some of the people who used the service also felt there was not always enough staff on duty. We have made a recommendation about this.

Management checks had not identified the issues we found. Care records were not always comprehensive or up to date and therefore did not accurately reflect people's needs. We received mixed feedback from staff. Some staff told us they did not feel well supported and they did not feel confident in approaching the manager. Surveys and meetings had been affected by the pandemic. We have made a recommendation about this.

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 7 June 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the management of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Piper Court on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, including the safe management of medicines, and good governance at this inspection.

In response to the concerns we found with infection prevention and control, we imposed conditions on the provider's registration requiring urgent action to be taken to improve the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
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 timeframe. 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Piper 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two 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. The Expert by Experience contacted people by phone to request feedback.

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

The service had a manager in post who was in the process of registering with the Care Quality Commission. Once registered, they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

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 and the Clinical Commissioning Group (CCG). The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and four relatives over the phone about their experience of the care provided. We spoke with 13 members of staff including the regional manager, manager, deputy manager, senior care workers, care workers and domestic staff.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed additional evidence including training data and quality assurance records. We spoke with an external health professional who was involved with service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

- On arrival to the home appropriate COVID-19 screening checks did not take place.
- Staff had received PPE training but were not up to date with current guidance and not all staff were wearing masks correctly. One member of staff was not bare below the elbow. These practices increased the risk of infection being transmitted.
- Staff were arriving and leaving the premises in their uniform and one staff member was working without a uniform. This increased the risk of COVID-19 entering the service.
- There was a lack of cleaning hours across shifts to enable effective cleaning. There were no cleaning staff in attendance for three days in May 2021.
- Some areas of the home were not cleaned effectively, and we observed poor infection control practices in one of the communal kitchen areas.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- Environmental health and safety and fire safety records had not been fully completed since January 2021. There were no records to show staff had participated in a fire drill and the manager, who started in December confirmed they had not taken part in one. We passed these concerns to Cleveland Fire Department.
- Risk assessments were not always in place or regularly updated. Where risks to people had been identified, care plans did not provide enough detail to guide staff on how to reduce these risks.
- Staff did not monitor fluid intake effectively. Where people had a daily fluid target to be reached because they were at risk of dehydration, this target was not always achieved. There was no evidence to demonstrate how this was being monitored and addressed to ensure people's safety and wellbeing.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines records did not assure us that medicines were being administered as prescribed. We could not be sure people were receiving their topical medicines as prescribed as records were not up to date and some medicines were unavailable. Medicines no longer needed were not handled in line with the providers medicine policy.

● Guidance to support staff in the safe administration of 'when required' medicines was not always present. Records that were in place required more information. Records for medicines prescribed with a variable dose did not always show how many tablets a person was given.
● Processes within the home to monitor bowel management were not robust, for example we found one person was recorded as having 11 episodes of mild diarrhoea over four days, yet a laxative was still being administered.
● The process for the self-administration of medicines was not in line with the providers policy. we could not therefore be assured people were being supported to safely self-administer their medicines.
● The service did not always follow their own policy in relation to the management of controlled drugs therefore we could not be assured the management team had effective oversight of these medicines.

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were happy with the way their medicines were administered. One person told us, "I am in pain so often but I tell them and they bring some pain killers."

Staffing and recruitment
● Staff we spoke to said there was not always enough staff on duty and the Grange (mental health unit) often worked with just one staff member. For one week in May 2021 they had no domestic or laundry cover for three days and the two days prior to this only one staff member was on duty to cover this work. One member of staff told us, "People are not getting the care they deserve. You have to be like a machine with no time to sit and talk to people."
● Some of the people we spoke with also felt staffing levels were an issue. One person told us, "[Staff] have told me constantly they are short staffed. When I call [staff] I wait for ages for them to answer and I tell them and they say sorry but they are a bit short staffed."

We recommend the provider reviews staffing levels in line with current best practice guidance and considering the needs of the people using the service.

● Staff were recruited safely. Staff underwent a robust recruitment process. Staff records included all required information, to evidence their suitability to work with people, which included a Disclosure and Barring Service check (DBS). The DBS assists employers to make safe recruitment decisions by ensuring the suitability of individuals to care for people.
● Records were in place to evidence nursing staff were registered with the Nursing and Midwifery Council (NMC).

Learning lessons when things go wrong
● Accidents and incidents were being recorded and an analysis was completed monthly to look for patterns and trends. This meant that lessons could be learned from the data and future risk reduced.

Systems and processes to safeguard people from the risk of abuse
● People we spoke with told us they felt safe and would report any concerns to staff. One person told us, "Of course I feel safe as they look after me."
● Staff had received safeguarding training. They were knowledgeable around safeguarding procedures and where to report and escalate any concerns.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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 systems in place for checking on the quality and safety of the service were ineffective. Audits failed to identify the concerns highlighted on this inspection, particularly around medicines management, infection prevention and fire safety.
- Care records did not always accurately reflect people's needs and were not fully updated when their needs changed.
- The manager did not have a good oversight of records. Some current documents had been incorrectly archived and errors on training records had not been identified.
- There was a lack of oversight by the management team to identify and pick up poor practice, such as, staff not wearing their PPE correctly and coming to work in their uniforms.

This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We received mixed feedback from staff about the management team. Whilst there were some positive comments made about the manager, seven out of 11 staff we spoke with gave some negative feedback. Some staff did not feel well supported. They told us concerns raised about staffing levels had not been acted on. One member of staff told us "I do not feel I can go to the manager. I have no confidence in them."
- People and relatives gave some positive feedback about the management team. However, not everyone had been introduced to the new manager who had been in post since December 2020. One person told us, "I think there has been a manager change. Haven't been introduced but they say hello in passing."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Surveys and meetings had been affected by the pandemic. Regular resident meetings had been stopped in order to keep people safe by avoiding large group sessions. One person told us, "Prior to COVID I attended a residents meeting, but then COVID came along and there has been nothing since."
- Staff meetings had started to take place again, however, staff did not feel the manager was approachable. One member of staff told us, "[The manager's] door is always shut with a sign saying they are in a meeting.

You rarely see them."

We recommend the provider looks at alternative ways of engaging with staff and people using the service to ensure they feel valued and involved.

Working in partnership with others

● There were some concerns regarding partnership working. The manager had failed to engage with IPC nurses in a timely manner when they reached out to provide support and training.

● The home had access to two National Early Warning Score (NEWS) kits. This equipment is provided by the NHS and is to be used to make regular observations of people living at the home. These observations give front line clinicians the information they need to make important decisions about a person's treatment. Staff were not using this equipment as intended and management at the home had not engaged with health professionals who had offered additional support.

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

● The manager understood their responsibilities around duty of candour and the need to submit the appropriate notifications to CQC. They understood their duty involved escalating their concerns to outside agencies, so action could be taken.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk to people's health and wellbeing were not adequately assessed. 12(2)(a)(b) Environmental health and safety checks were not regularly completed and fire drills were not taking place 12(2)(d)(e) Medicines were not managed safely and medicines policies and procedures were not followed. 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Checks and audits carried out to ensure compliance with regulations and to monitor standards at the service were not carried out effectively and had failed to identify areas of concern. 17(1)(2)(a) Records were not always up to date, accurate or complete. 17(2)(c)

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Poor infection control practices were placing people at increased risk of harm. 12(2)(h)

The enforcement action we took:

Notice of decision to impose urgent conditions on registration