The Royal Masonic Benevolent Institution

Prince George Duke of Kent Court

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 01 and 03 December 2015 and was unannounced. At our previous inspection on 28 and 29 April 2015 we found breaches in regulations because the provider did not take adequate steps to ensure care plans were completed in a timely manner for all the new admissions, and because they had not made notifications to the Commission as required. At this inspection we found that notifications had been made promptly where required and that care plans had been implemented for new admissions, although some improvements were required to address issues found in people's care plans.

Prince George Duke of Kent Court is a nursing and residential home providing accommodation, care and support for up to 78 people. At the time of our inspection there were 75 people living at the home. There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with

Summary of findings

the Care Quality Commission 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.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Records relating to people's care and treatment were not always accurate or contained contradictory information, and some records were not securely maintained. People's privacy was not always respected by staff because they entered people's rooms without knocking or because they knocked but didn't wait for a response before they entered. CQC has taken enforcement action to resolve the problems we found in respect of these regulations. You can see the enforcement action we have taken at the back of the full version of this report.

We also found breaches of regulations because sufficient staff were not always deployed to ensure people's needs could be promptly met when required. Staff were aware of the importance of seeking consent from people when offering support but were not always familiar with the requirements of the Mental Capacity Act 2005 (MCA). You can see the action we have asked the provider to take at the back of the full version of this report.

We found a further breach of regulations because risks to people were not always correctly identified in risk assessments and risks were not always safely managed. CQC is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.

Staff were supported in their roles through regular supervision and an annual appraisal of their performance. They received an induction when starting work for the service and had completed a range of training courses. The provider undertook appropriate recruitment checks on staff prior to them starting work for the service.

Staff were aware of the different types of abuse that could occur in a care setting and knew the action to take if they suspected any form abuse. They were aware of the provider's whistle blowing policy and told us they would use it if needed.

People received their medicines as prescribed and medicines were safely stored and recorded. People also had access to a range of healthcare professionals; however relevant referrals had not always been made promptly where required. There were arrangements in place to deal with foreseeable emergencies.

Information was available for people on how they could raise concerns and complaints were dealt with appropriately by the service. People's nutritional needs were met although kitchen staff were not always aware of people's food allergies. People were only deprived of their liberty in their best interests and when lawfully authorised in line with the Deprivation of Liberty Safeguards (DoIS).

Improvements were required to ensure people were involved in decisions about their care and treatment and to ensure their preferences in the way they were support were met. The registered manager undertook a range of checks and audits to monitor the quality of the service although these were not always sufficiently to ensure accurate analysis or to identify the issues we found during this inspection.

Staff spoke positively about the leadership of the service and regular meetings were held for staff, residents and relatives to help drive improvements. However people's views on the leadership of the service were mixed and whilst most people enjoyed the range of activities available at the service, improvements were required to ensure more people were engaged in activities they enjoyed.

Most people told us that staff treated them with kindness and compassion and we observed some good interactions between staff and people. However we also observed some interactions which required improvement and some people told us staff could be brusque.

Summary of findings

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.

Risks to people had not always been identified and action had not always been taken to ensure they were safely managed.

Sufficient staff were not always deployed in such a way as to ensure there were sufficient numbers to meet people's needs at all times.

Appropriate checks had been carried out on staff before they started work for the service.

Medicines were safely stored, administered and recorded.

There were arrangements in place to deal with foreseeable emergencies.

People were protected from the risk of abuse.

Is the service effective?

Requires improvement

The service was not always effective.

People had access to healthcare services and were supported to maintain good health, although referrals had not always been made promptly where required.

Staff were aware of the importance of seeking consent when offering support to people but were not always aware of the requirements of the Mental Capacity Act 2005 (MCA).

The registered manager was aware of the requirements of the Deprivation of Liberty Safeguards (DoLS) and had requested DoLS authorisations where required to ensure people's freedom was not unduly restricted.

Staff were supported in their roles through training and supervision.

People enjoyed the meals on offer at the service and were supported to maintain a balanced diet.

Is the service caring?

Requires improvement

The service was not always caring.

Staff could describe how they worked to ensure people's privacy and dignity were maintained, but people's privacy was not always respected.

Most people told us they were treated with kindness and compassion, although some people told us staff did not always experience caring treatment from staff.

Summary of findings

Some people told us they were involved in making decisions about their care and treatment. However other people said that their views about the support they received were not always taken into consideration.

Is the service responsive?

Requires improvement

The service was not always responsive.

People and relatives had been involved in discussions about the planning of their care, although improvements were required to ensure people's preferences were met.

Most people spoke positively about the activities on offer within the service. However improvements were required to meet people's need for stimulation because we observed people having little to do during our inspection.

There was a complaints policy and procedure in place and people were aware of how to make a complaint.

Is the service well-led?

Requires improvement

The service was not consistently well led.

The provider had quality assurance systems in place but these did not always identify issues or drive improvements.

Records relating to the care and treatment of people were not always well managed or securely maintained.

Staff spoke positively about the leadership of the service and regular staff meetings were held to ensure staff were aware of the requirements of their roles.

Regular meetings were with people and their relatives and the registered manager took action to make improvements from the feedback they received.

Prince George Duke of Kent 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 01 and 03 December 2015 and was unannounced. The inspection team on the first day consisted of three inspectors 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. Three inspectors returned to the service on the second day to complete the inspection.

Prior to the inspection we reviewed the information we held about the service and the provider. This included notifications received from the provider about deaths, accidents and safeguarding. A notification is information about important events that the provider is required to send us by law. We also contacted the local authority responsible for monitoring the quality of the service. We used this information to help inform our inspection planning.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support being delivered.

We spoke with 22 people using the service, seven visiting friends and relatives, a visiting GP, a visiting district nurse and a visiting social care professional. We also spoke with members of staff on duty during our inspection and looked at records, including care records of 14 people using the service, ten staff members' recruitment files, staff training records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe living in the home. One person said, "I am very safe here." Another person commented, "Oh yes, it is safe. It is secure." Most relatives also spoke positively about safety within the service. One relative told us that their loved one, "Is safe and cared for here. It has given me huge relief to know this." Another relative said, "We do feel that people here are safe, yes." However, despite a number of positive comments from people and relatives about safety, we found that risks to people's health and safety had not always been assessed and that action had not always been taken to manage identified risks safely.

Risk assessments relating to the use of bed rails had not always been conducted prior to their use on some people's beds. We found two examples where bed rails had been put in place for people without any form of risk assessment, and one of the two people had sustained an injury having become trapped between the rails. A risk assessment had subsequently been conducted and staff told us the rails were to be removed from the bed as they were not a safe option for the person in question.

Where risk assessments had been conducted, we found that they were not always up to date and did not always accurately recognise all of the factors that would contribute to decisions about risk management. For example, we reviewed the records of one person who had sustained a serious injury following a fall which required a stay in hospital. Their falls risk assessment had been completed to indicate that the person had no previously recorded falls in the last six months and their mobility care plan stated that they had no known falls within the last twelve months. However we found accident reports indicating that the person had fallen at least three times in the six months prior to the fall that caused the injury. Therefore we could not be assured that all possible action had been taken to reduce the risk of the person sustaining further falls because a number of previous falls had not been taken into consideration as part of the risk assessment and care planning.

When looking at the Malnutrition Universal Screening Tool (MUST), a tool to assess the risk of malnutrition, guidance used by the service we found that one person's weight had dropped by more than 10% over a three month period which placed them in a 'high risk' category. However, the person had been assessed as being at 'low risk' which meant their risk of malnutrition may not have been correctly recognised in order to be safely managed.

Risks were not always safely managed within the service. We found that one person was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation in order to protect them from the risk of leaving the building unescorted. Records showed that they had still managed to leave the service unescorted on more than one occasion, despite this being an identified risk, and that the most recent incident in which they had left the building had resulted in their sustaining minor injuries as the result of a fall.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). CQC is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.

People and relatives had concerns about the staffing levels within the service. One person told us, "They have taken on too many dementia residents because they clearly do not have enough staff for them all." Another person said, "The staff are always dashing around; they never seem to have time to sit and chat." A relative told us, "I have seen residents fall here. There are simply not enough staff." They also said, "Staff miss minor details because they are so rushed and these can lead to a lack of safety."

We observed staff to be busy throughout our inspection and not always able to spend time with people. One staff member told us, "With the level of needs a lot of the service users have, I really think we need more staff to keep them safe." People we spoke with also told us that staff were not always able to respond quickly when they used their call bells to request support. One person commented, "If I ring it, it is often not too bad but it can be 10 minutes or so." Another person explained, "When I ring it is usually only a few minutes to wait, but because they are so busy doing everything, you can wait much longer than you should. This can be a struggle, but I have to be realistic about it. They could do with more people."

We reviewed records relating to a recent staff meeting held to discuss call bell response times. The response times noted in the meeting minutes indicated that there had been eight instances of people having to wait for between

Inadequate

Is the service safe?

seven and 14 minutes, and one person having had to wait for 37 minutes for a response on a particular day during the previous month. We spoke to a senior member of staff about the reasons why there had been such significant delays in responding and they told us that staff had said they could not respond quickly because they were supporting other people. Therefore staff had not always been deployed in way which ensured there were sufficient numbers to meet people's needs at all times.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). You can see the action we have told the provider to take at the back of this report.

The provider had safe recruitment systems in place. We reviewed the personnel files of 10 staff and saw completed application forms which included details of their previous health and social care experience, their qualifications, employment history and explanations for any breaks in employment. The files also contained health declarations, evidence of criminal records checks, two employment references, proof of identification and evidence of the right to work in the UK where applicable. The personnel files for nursing staff also included details of their Pin number, which confirmed their professional registration with the Nursing and Midwifery Council [NMC].

Medicines were safely stored and managed. The service had systems in place to ensure that people received their medicines as prescribed by health care professionals. Where medicines were stored in people's rooms, we found that these were kept securely in locked cupboards. Other medicines were safely stored in specifically designated rooms which were kept locked and were only accessible by staff trained in the administration of medicines. Regular temperature checks were made of storage areas to ensure they remained within the range for the safe storage of medicines.

People's medication administration records (MARs) were up to date and either confirmed that medicines had been administered at the prescribed times, or recorded the reasons why any medicines had not been administered. A photo of each person was kept with their MAR as well as details of any known allergies to help reduce the risks associated with the administration of medicines. Staff responsible for administering medicines had received appropriate training; however some improvement was required as not all staff had been assessed to ensure they were competent in this area.

There were arrangements in place to deal with foreseeable emergencies. Personalised emergency evacuation plans had been developed for each person using the service, which were readily accessible if required. Staff we spoke with had received fire safety training and had attended fire drills. They were aware of the action to take in event of a fire or emergency.

There were procedures in place to protect people from the risk of abuse. Staff had received training in the area of safeguarding adults and demonstrated a good understanding of the subject. They were aware of the different potential types of abuse that could occur and could describe the action they would take if they identified any potential safeguarding concerns. One staff member told us, "It's important to be alert and watch out for anything unusual." The registered manager knew the process for reporting any allegations of abuse to the local authority safeguarding team in line with local requirements. Staff we spoke with were also aware of the provider's whistle blowing policy and told us that they would be confident to escalate any concerns they had to an appropriate external party if needed.

Requires improvement

Is the service effective?

Our findings

People and relatives we spoke with were happy with the meals on offer at the service. One person told us, "The food is lovely. There's a cooked breakfast. They bring round a menu the day before; there's always a choice, and plenty to eat." Another person said, "There's plenty to eat, and a good choice too." A relative we spoke with told us, "We have eaten here; it was all great food. They accommodated our vegetarian requirements in an instant." Another relative stated, "The food is well cooked. There's a good choice, quite enough, and they are shown a menu, too; I liked that."

People's nutritional needs were met but we found concerns relating to staff awareness of people's food allergies. Kitchen staff had information about the dietary needs of the people living in the home, for example if they were diabetic, required a soft diet or if they had any food allergies. However we found two peoples care plans had identified specific food types that they were allergic to which kitchen staff were not aware of.

This issue was a further breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). CQC is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.

The service offered a four weekly menu, which was adjusted seasonally. We saw there was a choice of main meal and a vegetarian option. The chef was aware one person at the service had cultural dietary needs and what these were. They said they would be able to cater for anyone's cultural needs and preferences on an individual basis. People made choices about their meal options during the previous day, but could change options if they wanted to on the day. We also saw options were available if they didn't like the choices. Sandwiches were available on the units for anyone needing a snack at night and there were afternoon snacks and plenty of drinks provided during the day. The kitchen was accessible to staff at night if needed.

We observed there to be sufficient staff to meet people's needs during meal times. Staff were on hand to offer support to those who required it and we saw some good interactions between staff and people, with staff encouraging people in a calm and friendly manner and not rushing them while they ate. However we also noted that staff did not always consult people before serving food onto their plates as to whether they wanted what was on offer, or on the size of the portion being served.

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 this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training on the MCA and most staff we spoke with were familiar with the requirements of the Act and were aware of the importance of obtaining consent from people when offering them support. One staff member told us, "I believe that everyone has a level of Capacity." Another staff member said, "I always seek consent when offering people support." However, we found that arrangements to obtain consent and work within the MCA were not always in place.

Whilst we saw examples of mental capacity assessments having been conducted, and best interest's decisions made in line with the requirements of the MCA Code of Practice, one staff member we spoke with was not aware that mental capacity assessments should be made relating to specific decisions. They identified a person as lacking capacity in general, and showed us their records which included a mental capacity assessment which made no reference to a specific decision. The assessment also identified the person as having capacity, despite the staff member's view that they did not. Therefore there was a risk that staff were making decisions about the person's care and treatment without consulting them.

Requires improvement

Is the service effective?

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). You can see the action we have told the provider to take at the back of this report.

The registered manager understood the process for requesting authorisations under DoLS where required, and we saw that requests had been made appropriately, and a number of authorisations granted to ensure people's freedom was not unduly restricted. Any conditions that had been imposed on DoLS authorisations by the managing local authority were met by the service. We also saw that the service had a process in place which senior staff used to follow up with relevant authorising bodies where authorisations were still outstanding.

Staff received appropriate training and support to undertake their roles. Staff we spoke with confirmed that had undergone an induction when starting work at the service. One staff member said, "It was really good, I was assigned a buddy who I shadowed." A senior staff member told us that the service was in the process of updating the induction process and that they had just completed training to become an assessor for staff to gain their Care Certificate (a nationally recognised standard published by Skills for Care).

Staff undertook training covering a range of topics including moving and handling, fire awareness, infection control, health and safety, first aid, safeguarding, and food hygiene. Records showed that most staff were up to date with this training which was refreshed on a regular basis and we saw further courses scheduled for staff to attend. One staff member explained, "Training is non-stop; they're very hot on it here."

Staff were also supported in their roles through regular supervision and an annual appraisal of their performance which they told us they found to be helpful. One staff member said, "Whenever I've raised issues during supervision, the manager's feedback has really helped me." Another staff member told us, "The discussions I have with my manager have helped me to think about how I can improve." Records confirmed that most staff had received supervision on a quarterly basis, in line with the provider's policy, and where supervision sessions had been missed, we saw that the relevant staff members had been contacted in writing to make alternative appointments.

People had mixed views on their access to healthcare professionals. One person explained that they regularly saw GP and received visits from a district nurse to change a dressing. They spoke positively about this, telling us, "My legs don't swell now," based on the advice they'd received. Another person confirmed that they saw a GP when needed, telling us, "A very good doctor comes here." However, a third person told us of staff, "They mess me around. They tell me I'll see a doctor and then not," although they also confirmed that they had seen the GP whilst living at the home.

Records showed that people had access to a range of healthcare professionals in order that they maintain good health, including a GP, Speech and Language Therapist, District Nurse and Chiropodist. We spoke with a visiting GP who praised of some of the staff working on the nursing unit at the service. The GP confirmed that these staff were aware of people's current conditions and that they made prompt referrals when required. However, we found referrals had not always been promptly made where required. For example, we found a letter from a GP in one person's care records informing them that they were due a diabetic review and that they required a blood test, but staff we spoke with were unable to provide evidence that the blood test or review had been arranged. A visiting chiropodist had also recommended on 26 November 2015 that the same person be referred to the district nurse in order to have a dressing changed and to follow up on a loss of sensation in their feet. We spoke to the person in question and they told us that they had still not seen the district nurse at the time of our inspection and staff we unable to identify whether a district nurse referral had been made.

These issues were a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). CQC is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.

Requires improvement

Is the service caring?

Our findings

People and their relatives had mixed views about the care provided by the service. One person told us of the staff, "They are very willing here, lovely people, and dedicated, but so pushed." Another person said, "They [staff] are always willing to stop what they are doing to help you." However, other people's feedback was less positive. One person commented that, "There are good and bad staff. Most are helpful, but one or two are not." Another person told us, "Some are kind, but some are brusque," and a relative described having seen staff "talking over people in bed" rather than engaging with them when providing support.

Staff we spoke with were able to describe the ways in which they worked to ensure people's privacy and dignity were respected, for example by closing the doors to people's bedrooms when offering support with personal care, or confirming that people were happy with the level of support they received. However, we found that some staff were failing to respect people's privacy with their actions. For example, we saw staff entering people's bedrooms without knocking, or failing to wait for a response before entering. These observations were supported by feedback from people we spoke with, and from a visiting healthcare professional. One person told us, "They do not knock; it can be very disconcerting. They come in and then knock, which is ridiculous." Another person told us, "Staff do not always knock when coming into my room," and the visiting healthcare professional stated, "Not everyone knocks. I make a point of demonstrating to staff the need to wait to be invited into the person's room, which really is their home."

These issues were a breach of regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. CQC has taken enforcement action to resolve the problems we

found in respect of this regulation. You can see the enforcement action we have taken at the back of the full version of this report.

We observed some caring interactions between staff and people during our inspection. For example, where a person became upset because they had not seen a family member, we saw a staff member offering comfort to her by holding their hand and reminding them that the family member would be coming soon. In another example we observed staff taking their time to offer support in a calm and relaxed manner to one person while they were mobilising. However, we also noted some poor interactions which required improvement. For example, we observed staff during a lunchtime meal failing to consult people about their meal options whilst serving their food. In another example we observed one staff member showing little interest in a person whilst supporting them to go to the dining room.

People and relatives we spoke with did not always feel involved in decisions about their care and treatment. For example, one person described having been supported to get out of bed on the morning of the inspection, despite their being able to do so themselves and not wanting the support. We spoke to senior staff about this incident at the end of our inspection and they confirmed that the person was able to get out of bed independently if given time. They told us they would speak to the staff involved in offering support that morning although we were unable to confirm this had taken place during our inspection. Other people we spoke with were more positive about their involvement. For example, one relative told us, "We discussed [their loved one's] care needs with staff. They gave us information about the home so we could make the right decisions."

Relatives told us there were able to visit their loved ones whenever they wished and that most staff were warm and welcoming. One relative said, "Everybody makes us welcome whenever we come and we are offered tea." Another relative explained that the registered manager had shown them where they could make their own hot drinks when they visited which they were pleased about. They added, "They all made us welcome straight away here."

Requires improvement

Is the service responsive?

Our findings

People and relatives had been involved in discussions about the planning of their care, although improvements were required to ensure people's preferences were met. A staff member said, "We talk to the residents and their relatives to ensure we know what they want from their care." However, some people told us their views and preferences were not always taken into consideration in the planning of the care they received. For example, one person told us, "It is a regime and I am not keen on regimes. You cannot stay in bed." Another person explained that they were unable to have a bath as often as they wished, telling us, "All my life I have had a bath every morning and they say they haven't got time." They also told us that they had a sight problem they had asked for a commode near the bed but had been told they could not as it would mean that staff had to check them every hour at night. This person could not understand how they were allowed to walk much further to a toilet without check but not allowed a commode. We spoke to the registered manager about this and they told us they would look into arranging a commode for the person.

At our last inspection we found that people's care plans had not always been implemented promptly upon admission. At this inspection we found that care plans had been implemented in a timely manner, but that some improvement was required in the way the planning of their care was recorded. People's care plans contained some information about their personal history, preferred social activities and the things that were important to them. Staff we spoke with told us that care plans were reviewed with people on a regular basis, although review dates were not always clear on the electronically held care plans we reviewed and the opinions of where review dates should be displayed on the system varied depending on which staff member we spoke with.

Most care plans had been completed to indicate people's preferences in how they received support from staff, and highlighted the things they could do for themselves in support of their own independence. However, we also found examples where the care planning template used by the service to develop people's individual care plans had not been adequately edited which meant some people's care plans contained contradictory statements about their goals and wishes. For example one person's care plan relating to their personal care stated their wish to maintain their independence with their personal care as well as their wish to maintain their personal care with support.

We also found that records relating to people's care and treatment had not always been maintained or were inaccurate. For example, staff were only able to locate records relating to the checks made on people at night for three of the previous eight nights when we requested them, so we were unable to establish whether the level of support offered to people at night was in line with their needs and preferences.

These issues relating to the maintenance of records were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). CQC has taken enforcement action to resolve the problems we found in respect of this regulation. You can see the enforcement action we have taken at the back of the full version of this report.

There were mixed views about the activities on offer to people to people within the service. One person told us, "They organise things all the time; bingo and word games. There is exercise to music and entertainers." Another person said, "We had a lovely entertainer with a Wurlitzer and sometimes the organisers take us shopping." A visiting relative told us, "I have seen a choir, a music session, and a harvest festival." She added, "They have a weekly programme of what is going on; they had fireworks and you can request that (your loved one) goes on the outings." However another person commented that they didn't find the activities on offer to be particularly stimulating and a relative was concerned that their loved one hold told them that they, "Sit in their room all day." Whilst we saw that a range of activities were promoted within the service, some improvement was required to meet people's need for stimulation because we noted that a significant number of people did not have anything to do in the day times during our inspection.

The provider had a complaints policy and procedure in place which was on display within the service to raise people's awareness of how to raise concerns if they had them. People and relatives were aware of how to make a complaint if they needed to. One relative we spoke with told us, "Anytime I have a concern, I have mentioned it and they have taken notice." Another relative told us they would speak to the registered manager if they had any issues. We

Requires improvement

Is the service responsive?

also saw minutes from a recent resident's meeting where people were reminded of the process how to make a complaint and were encouraged to left staff know if they had any issues.

Records of complaints were maintained by the service. These included details of the concern and any investigation, and a copy of the responses. We saw that where concerns had been raised, they had been dealt with appropriately and within the provider's timescale for responding to complaints.

Requires improvement

Is the service well-led?

Our findings

The views of people and their relatives on the leadership of the service were mixed. One person told us, "It is all very generous here and well run… I am lucky to be here." A relative said, "I think it is a very good home, and well-run." Another relative also spoke positively of their experiences in dealing with the management team when their loved one recently moved into the home, telling us that they'd promptly addressed any minor issues they'd raised during the initial weeks. However, other comments were less positive. For example, one relative expressed concerns, telling us, "Good leadership is lacking here," although they did also make reference to some signs of recent improvement in the running of the nursing unit. Another relative told us that they'd previously raised issues with the management team but explained, "It does not improve. I have no faith at all." The mixed views of people were reflective of our findings in that whilst elements of the service were well run, we found some improvement was required.

The registered manager undertook a range of checks and audits to monitor the quality of the service and identify areas for improvement. These covered areas including medicines, care planning, analysis of incidents and accidents, infection control, call bell response times, the environment, and aspects of health and safety. The provider also undertook mock CQC inspections to identify whether the service was meeting the requirements of the Health and Social Care Act (2008) Regulated Activities 2014. Where issues had been identified, we saw that some improvements had been made. For example, we saw that the level of staff supervision had increased in response to concerns found during a mock inspection conducted in July 2015. However improvement was required because some of the checking processes used by the service were not sufficiently robust to identify trends in concerns. For example, we found that details of incidents and accidents had not always been properly recorded and therefore could not be analysed with any accuracy. We also found that audits of people's care records had not identified the issues with some people's care planning and risk assessments. We also noted that whilst the provider had held meetings with staff in response to their monitoring of call bell response times, the action taken did not guarantee any level of improvement.

Records relating to the care and treatment of people were not always well managed or securely maintained. The provider had implemented an electronic system to maintain records about people's care and treatment. Staff we spoke with were not always confident to use the system and could not always promptly locate specific records when requested to do so. We also found that some elements of people's care plans were stored in paper files, although there was no consistency across the service as to which records were stored where, which led to further confusion amongst staff as to where they should look. For example, we found some mental capacity assessments were stored as paper copies in some cases, whilst others were stored electronically.

We also found care records relating to different people loose in a drawer in the office. Staff we spoke with told us that these records related to people who had passed away. These records had become mixed together making it difficult to identify who they related to. This was a further breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). CQC has taken enforcement action to resolve the problems we found in respect of this regulation. You can see the enforcement action we have taken at the back of the full version of this report.

At our last inspection we found that notifications had not always been made by the provider as required under the requirements of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found improvements had been made. There was a registered manager in post at the time of our inspection who understood the requirements and responsibilities of their role. They were aware of current legislation relevant to the operation of the service and had submitted notifications of events which required notification to CQC promptly when required.

Staff spoke positively about the leadership of the service. One staff member told us, "The management team are very supportive and easy to talk to. They listen to my concerns." Another staff member said "I feel supported here; the team work is very good." A visiting healthcare professional also spoke positively of teamwork within the service, telling us, "The shift leaders lead well, and work as a team."

The service held regular staff team meetings to discuss the running of the home. Areas discussed during the meetings included updates on the provider's policies and

Requires improvement

Is the service well-led?

procedures, health and safety issues, safeguarding and training requirements. Action had been taken where issues had been raised. For example we noted that an issue relating to call bell alerts not signalling on some staff pagers had been raised during a recent team meeting and confirmed with the registered manager that this concern had subsequently been addressed. We also observed a handover meeting between shifts during which information relating to people's daily needs, or any changes in their condition were shared with the new shift to ensure continuity in their care and support.

People were asked for their views of the service. The provider conducted an annual survey to gain feedback from people using the service and their relatives. However, one relative we spoke with told us they considered the questions asked to be more relevant for people on the residential, rather than the nursing unit, and that the questions asked were not always relevant to people's needs. The registered manager told us that the 2015 survey had only just been completed and that the results were still in the process of being collated so we were unable to review this at the time of our inspection.

Regular meetings were also held for relatives and residents to discuss day to day issues at the service. Areas discussed included the activities on offer, catering within the service, staffing updates and updates on the maintenance of the building. We noted positive comments made by relatives in the minutes from a relatives meeting relating to improvements made to the maintenance of the building and that the registered manager encouraged relatives to offer feedback on their experiences of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Staff were not always aware of the requirements of the Mental Capacity Act 2005.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff were not always deployed in sufficient numbers to meet people's needs.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's privacy was not always respected.

The enforcement action we took:
A warning notice was served on the provider and registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records were not always accurate or securely maintained.

The enforcement action we took:
A warning notice was served on the provider and registered manager.