The Royal Masonic Benevolent Institution Care Company

Cadogan Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 28 February, 2 and 7 March 2017. The provider, Royal Masonic Benevolent Institution (RMBI) is part of the Masonic Charitable Foundation whose motto is 'a new charity for Freemasons, for families, for everyone' and runs 20 care services nationally. Cadogan Court in Exeter is registered to provide accommodation for up to 70 people who require nursing and personal care. The service consists of seven units over three floors known as; Holman, Barrington and Colenso-Jones, which provide care for older people who require residential care; Kneel and Osborn, which provide nursing care for older people; and Alford and Eliot, which provide care for older people living with dementia. Alford unit had recently opened as a specialist dementia care unit, since the last inspection. The needs of people in the home varied. Some people had complex nursing needs and remained in bed; some people had mental health needs and needed support and supervision while other people were relatively independent and needed little support. At the time we visited, 64 people lived at the home.

There was a registered manager employed at the home. A registered manager is a person who has registered with 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 and associated Regulations about how the service is run.

At the last inspection in July 2016 we found the domains of 'safe', 'effective' and 'responsive' required improvement. At the time, people, relatives and staff expressed concern that agency staff (staff used from an agency to support permanent staff on a temporary basis) did not always have the knowledge and skills to meet people's needs safely. In addition some care plans had not always provided the guidance staff needed to meet people's care needs safely and effectively. At this inspection we found this had been addressed and systems were in place to ensure agency staff could easily access important information they needed to meet people's needs. Care plans were now comprehensive and ensured staff had good information to ensure they knew how to meet people's care needs. At the last inspection we found that people's legal rights had not always been fully protected because some people had restrictions in place, such as bed rails or pressure mats, but there had been no consideration of whether these restrictions were in their best interests. At this inspection we found this had been addressed and the home was meeting these legal obligations. People had access to healthcare services for on-going healthcare support, however at the July 2016 inspection health and social care professionals had not always known if their recommendations had been shared with staff or acted on due to a breakdown in communication.

At the last inspection in July 2016 we also rated 'well led' as requiring improvement. This was because the home had been without a registered manager for five months, and at the time of the inspection was managed by the current registered manager who at that time was newly registered with the Care Quality Commission. At that inspection staff told us the previous manager had "not been there very much", and there had been little improvement in the service over an 18 month period. The provider and new registered manager had identified where improvements were needed and developed a comprehensive service improvement plan. However, whilst we were confident that the provider had recognised the failings and put

in place actions to address them, previous systems had not been successful in maintaining the quality of service provision. At that time it was therefore not yet possible to determine whether these actions would be effective in keeping people safe and improving the quality of support provided. Therefore, at that time some aspects of the service were not well led as there had been no leadership at the home for some time which had impacted on the quality of the service.

Although the above issues had now been addressed and the service improvement plan was on-going, we found that systems in place did not ensure the following concerns found at this inspection had been identified and actioned effectively.

People were not always safe at Cadogan Court because there were not enough staff, particularly on the residential units. A recruitment drive had been in place for some time and continued to fill staff vacancies and the registered manager was keen to recruit good quality staff over time. The current use of agency staff in relation to permanent staff was around 17%. However, although the registered manager had listened to staff concerns about low staffing levels, identified a need for more care staff and submitted a business plan to the provider, which was in progress, we found the staffing levels for the home were lacking at the time of our inspection. This meant that although staff were caring and worked hard to meet people's basic needs, they were physically unable to ensure person centred care in a timely way and people living at Cadogan Court with more complex needs were put at risk. For example, people's basic needs were mostly in the morning when staff assisted people to get up but during the inspection staff did not have time or enough staff to maintain people's continence effectively, assist people with their meals in a timely way, meet people's social needs consistently or supervise those people identified as at risk of falling despite the use of preventative equipment.

Although people were supported by very kind, caring and compassionate staff who tried to promote people's independence and treated them with dignity and respect, they were unable to ensure that people's dignity was maintained at all times. For example, we had to ask staff to assist a person who was not completely covered, with their door open.

We contacted the provider following our first day of inspection to inform them of the need to increase staffing levels especially on the residential units. The provider immediately increased staffing on the residential units the next morning. There was a positive outcome when we rang the home to monitor the situation and when we visited on the second day of our inspection. For example, emergency call bells were not ringing constantly, people's needs were ,met and staff told us they were much happier working effectively. Care staff were more visible and felt able to meet people's needs effectively as they could work together and did not have to use the call bells to summon assistance of a second care worker, often from another unit.

Although there were quality assurance systems in place to monitor all aspects of the home to identify areas for improvement, including a new dependency assessment tool, they had not clearly identified the urgency for a safe level of staffing in practice. We also found that due to lack of staffing, medication rounds were taking too long, resulting in some people not receiving medication when it was due, such as 'before food'. Some records relating to medication were not clear about medication described as 'as required' to enable staff to know when and why to offer this medication.

Although there were two activity co-ordinators and opportunity for people to attend external entertainment opportunities we found that some people were not facilitated to maintain regular social stimulation in a person centred way to maintain wellbeing. During our inspection some individuals were left for long periods alone and staff did not have time spend with people or to have input into activities and social stimulation.

The activity co-ordinators were employed for 52 hours per week to meet the needs of 70 people. This meant that people had little contact with staff other than for tasks and some people with more complex needs such as living with dementia or other mental health needs were not consistently supported. Staff were unable to be pro-active in ensuring care was based on people's preferences and interests, join in and seek out activities in the wider community and consistently help people live a fulfilled life, individually and in groups.

The registered manager had been employed at the service for just over a year and provided good leadership and had responded to the issues raised at the last inspection, resolving issues to ensure a more stable, competent staff team and working with the local social services quality assurance and improvement team. There were clear job roles, support and boundaries and discipline for staff with clear lines of accountability and responsibility. They were proactive in building a culture of transparency and openness at the home. Staff support and training had been improved as well as information sharing as a team and within the wider healthcare professional community where positive relationships had been built for the benefit of the people living at Cadogan Court. People, relatives, staff and external professionals had confidence in the registered manager and spoke highly of them, however they all expressed concerns about the low level of staffing.

Staff were clear about their individual roles and responsibilities and although they felt valued by the registered manager, deputy manager and senior management team they felt let down by the lack of effective staffing levels. However, people and the staff knew each other well and these relationships were valued, the staff did the best they could with the resources available and tasks such as personal care, managing health needs and maintaining nutrition were completed well. People were well kempt and assisted to make choices such as when they got up, what they ate and when they ate. People had call bells and drinks accessible and were generally comfortable.

All staff had received appropriate training, since the last inspection, in line with nationally recognised qualifications and regular supervision to provide them with the necessary skills and knowledge to provide people with effective care. Staff were knowledgeable about people's needs and were able to ensure that health concerns were identified and highlighted with appropriate actions taken in a timely way including referral to external health professionals.

People received a nutritious diet and enough to eat and drink to meet their individual needs and timely action was taken by the staff when they were concerned about people's intake and weight. People's individual nutritional requirements were assessed and they received a diet appropriate to their needs and wishes. The catering and care staff worked hard to make mealtimes an enjoyable and sociable experience for people, wherever they chose to take their meals. One care worker said the dining room was the nicest place in the home.

The home was clean and free from offensive odours. However, domestic staff had recently taken on the role of maintaining tidying and bed making in people's rooms rather than care staff as a measure to give care staff more time for care tasks. This had resulted in some beds not being made until late afternoon and bins were not always emptied or rooms tidied in a timely way due to the pressures on domestic and care staff. We fed this back to the registered manager following our first day of inspection and by the second day this role had reverted back to care staff who were now able to ensure these tasks were completed in a more holistic way for people.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, medication, person centred care, dignity and respect and good governance.

We are taking further action against this provider and will report on this when it is completed. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 always safe.

Although risks to people's safety had been assessed and preventative actions taken to reduce the risks of them experiencing harm, there were not enough staff to ensure people remained safe and receive individualised care in a timely way.

People did not always receive their medicines when they needed them as there were not enough staff.

Systems were in place to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective in ensuring people's needs were met although changing health needs were met in a timely way.

Staff and management had the knowledge and skills to provide people with care to meet their individual needs.

People's rights were protected by staff who understood their legal obligations including how to support people who could not consent to their own care and treatment.

People had a choice of appetising and nutritious food and drink and they received enough to meet their individual needs in a sociable environment.

Is the service caring?

Requires Improvement

The service was not always caring.

Although, the staff cared deeply for the people they provided care for, the lack of care staff did not ensure people's dignity and respect were always maintained.

Staff were kind, caring and compassionate and worked hard to meet people's basic needs despite the lack of staff.

End of life care planning was lacking and did not ensure people's

needs were known and met.

People and their relatives, where required, were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive, especially in relation to meeting people's social needs and maintaining wellbeing.

Staff were not able to provide individualised care to people to maintain their quality of life and wellbeing due to the lack of staff.

People's individual care needs and preferences had been assessed and basic needs were being met but staff did not have time to consistently encourage new opportunities and promote independence for everybody.

People could be confident complaints and concerns were taken seriously and dealt with to promote improvement but response to concerns about lack of staffing had been slow.

Is the service well-led?

Inadequate

The service was not always well-led.

Although, there was an open, inclusive culture within the home where people, relatives/friends and staff could voice concerns, those relating to low staffing levels were not always addressed in a timely way.

Good leadership, openness, support and visibility were demonstrated by the registered manager and senior staff team but concerns raised by staff through the registered manager were not appropriately addressed by the provider in a timely way.

Quality assurance systems did not ensure people received a good quality service driven by responsive improvement in a timely way in relation to low staffing levels, which also affected the timeliness of medication and ensuring people's social needs were consistently met.

Cadogan 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 28 February, 2 and 7 March 2017 was unannounced on the first day. The inspection team consisted of one adult social care inspector and a bank inspector.

We reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. A recent whole home safeguarding process had raised concerns about medication errors and low staffing levels, which the registered manager and provider were informed of. Issues relating to medication errors had been addressed well.

During the inspection, we spent time with twenty people living at Cadogan Court from across the seven units. We spoke with two visiting relatives, two visiting health professionals, the registered manager and deputy manager and the provider nominated individual (NI) at RMBI. We spoke with a senior shift manager, a shift manager, two registered nurses, eight care staff, three agency staff and the agency registered manager, an activity co-ordinator, the operations co-ordinator, three waitresses and two domestics. Due to some people living with dementia, they were not always able to comment directly on their experiences at the service so we joined 32 people for lunch in the main dining room. We also spent the majority of time on the residential units on the first day and also time observing care in the communal areas.

The records we looked at included six people's care records, 17 people's medicine records and other records relating to people's care, three staff recruitment files and staff training records. We also observed a medicine round. We also looked at maintenance records in respect of the premises and records relating to how the provider monitored the quality of the service such as complaints, audits and quality assurance surveys.

Inadequate

Is the service safe?

Our findings

At the last inspection in July 2016 we found this area required improvement. This was because there was a high number of agency staff which put people at risk because they did not always have the knowledge needed to provide safe care. The registered manager has now addressed this issue by ensuring regular agency staff and improving handover and communication about people's care needs, for example. At that time care plans did not consistently provide the guidance staff needed to meet people's care needs safely. These had been updated and more detailed along with summaries kept discreetly in people's rooms to enable agency staff to easily find important care needs information.

On the first day of our inspection, people were not always safe, especially on the residential units, because there were not enough staff to manage risk, respond to call bells and maintain people's continence in a safe and timely way. Staff and relatives all told us without prompting there were not enough staff. One person said they were lovely staff but they felt 'frustrated' at having to wait for staff to answer their call bell. One person was in their room trying with difficulty to use a grabbing aid so we approached to check if they needed help. When we asked if they had any difficulty getting the staff they replied, "Oh definitely!", saying their bin had not been emptied for several days. They told us there were not enough day staff in their opinion, with week-ends being worse. They added they waited more than six minutes with "not much effect". She said this caused "uncertainty" as they liked routine as they had a panic disorder. They said they needed "someone to come in and chat, and I like to know who is going to undress me, but I've usually not seen anyone to ask."

Call bells were set to go to a sustained emergency ring after six minutes. This sound was heard almost constantly throughout our first day. This was mainly due to care staff ringing the bell to request assistance from a second care worker to assist with people's continence and mobility. One relative said overall the home was "ok" but it was short-staffed. Other family members and an Age Concern volunteer had also noticed this. The relative gave an example that their relative sometimes waited 30-40 minutes to use the commode, which was a problem as they needed assistance quickly due to their medical condition. Two agency care workers said they often found people wet and needing assistance because staff could not find another care worker to assist in time. One said, compared to other care homes they had worked in, this one was 'busy'. One person told us, "It all stems from the fact they don't seem to have enough carers, so everything is rather shoddy and rushed. I have to use a commode and I have to wait for ages as I need two carers, by which time my trousers and underwear are wet, which is very demeaning."

The three residential units were regularly staffed by one care worker on the staffing rota with a floater (a care worker covering the three units) and support from a senior care worker and shift leader. However, it was difficult for care workers to find a second care worker to assist them with those people who required two care workers. Care staff were not visible and often engaged in people's rooms and there was no easy way to locate available staff other than to look outside rooms to see if the call bell showed a care worker present. We saw on repeated occasions that the one care worker allocated on the residential units was absent, looking for equipment or another care worker to assist them, leaving a residential unit empty of staff. The registered manager said a new stand aid had been ordered to ensure all units had the required equipment

to mobilise people. One care worker said they often didn't bother requesting another care worker as there was no point. This raised the issue of whether some care staff were mobilising people alone rather than waiting for assistance as stated in care plans for people who required two care workers to mobilise, which put staff and people at risk of poor manual handling. One relative told us on one occasion only one care worker had hoisted their relative when there should be two staff, as the second had to go to a meeting.

We asked staff to tell us about people's dependency levels, their level of need, especially on the residential units where 28 people lived. These units were covered by one care worker on each unit, with another helping over the three units and assistance from a senior and senior shift leader. On Holman- five people needed two to maintain continence and mobility and 2 people needed assistance with eating and drinking; Colenso- 2 people required two care workers to mobilise and one person needed assistance with eating and drinkning and Barrington- four people needed two care workers to mobilise and two people needed assistance with eating and drinking. Six people had regular 30 minutes observations and 19 people were identified as being at high risk of falls. Some of these people had preventative falls measures in place as part of their risk care plan such as pressure mat alarms. However, at times if the alarm had gone off to show a person was attempting to mobilise without assistance, it would not always be certain that a care worker would attend in time as they would with be with another person or not on the unit. Falls were rated as high risk on the service improvement plan as assessed by the registered manager. One person had fallen the night before our inspection and again in that morning and had gone to hospital for a check-up with a care worker.

There were many examples which showed there were not physically enough staff to supervise and be available to respond to people and manage risk. Many people were in wheelchairs for long periods, especially after lunch as 18 people needed wheelchair assistance to the main dining room. One person with limited sight had to sit at their table for half an hour as others finished their meal as they required assistance and a care worker was not available. The waitress rang the unit but the care workers were busy assisting someone else. They said this often happened. One person said they didn't ask to go in a chair as it was too much bother for staff. One person sat without a call bell in a wheelchair in reception from 4-6pm so we had to ask the registered manager assist them. One of her slippers had fallen off and their foot felt very cold so we replaced the slipper for them. Other people attended external activities in their wheelchair, which were intended for transportation not for comfortable seating for longer periods and there were no care workers attending external activities. One person was at risk of slipping out of bed when we passed their room so we had to ask care workers to assist them.

We met one care worker at 3pm who was with a person receiving care at the end of their life. The care worker said they had known the person had been incontinent at 1pm, meaning their bed and night wear was wet. The care worker said they had tried to assist the person with lunch but had still not found a second worker to assist them help to mobilise the person at 3pm when they were still wet. We ensured the person was assisted into clean clothes and bedding immediately. The care worker was distressed at the lack of care staff. Another person on Kneel unit was shouting out consistently. They calmed when we sat with them and prompted them with their drink. There were no staff visible. One care plan detailed that someone walked alone using a stick, and that their mobility was good with the use of their stick, but they needed to be shown the way because of their memory problems. They were walking up and down the corridor with no staff present. Another person on Eliot living with dementia was wandering around anxious asking for a drink. There were no staff around so we walked with them for a while. They kept saying "where shall I go?" Staff later told us this person often spent time in the lobby, but also enjoyed being in Alford lounge and doing crosswords but there were no staff to facilitate this. One care worker on Alford was trying to do some activities in the lounge diner. One person who had a known history of repeatedly dislocating their hip was mobilising unsupervised in the corridors. The second care worker was on a break.

The home was clean and free from offensive odours. However, domestic staff had recently taken on the role of maintaining tidying and bed making in people's rooms rather than care staff as a measure to give care staff more time for care tasks. This had resulted in some beds not being made until late afternoon and bins were not always emptied or rooms tidied in a timely way due to the pressures on domestic and care staff. A care worker told us in the afternoon on the first day of our inspection they were having to go around making beds that were still unmade, tidying rooms and emptying pad bins and manage soiled washing. Domestic staff had raised the issue with their line manager as an unsatisfactory situation due to the time it took and having to keep swapping gloves to maintain proper infection control.

Care workers also had other tasks during their shift such as giving out hot drinks mid morning and mid afternoon and washing up and maintaining people's continence. In the morning care staff were also responsible for preparing and serving people's breakfasts for those who chose not to use the main dining room, including collecting cooked items from the kitchen if someone wanted a cooked breakfast. On the residential units there were at least seven people who regularly ate in their rooms. There were eight people on this unit who required assistance with their continence which took at least 20 minutes each time and two care workers every couple of hours. This meant there was too much for staff physically to do with the number of staff allocated.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our concerns about staffing levels, especially on the residential units, to the registered manager and the provider after our first day. The provider immediately ensured their were two further care workers in place from the next day which meant care workers were now able to work in pairs on these units. When we visited a day later the unit was much quieter with call bells only sounding intermittently. The registered manager showed us a call bell log which showed a much reduced level of use as staff did not have to use them to summon a second care worker. Staff were more visible and sought us out to tell us how happy they were to have been listened to as they now felt they had enough staff to meet people's needs in a timely way. We did not see any people in distress or calling out and people appeared to have their needs met. The provider also increased staff by one care worker on the dementia unit and a new role of clinical lead was to be recruited. We also fed back the issue of domestic staff being responsible for bed making and tidying in people's rooms as the arrangement was not working and by the second day this role had reverted back to care staff who were now able to ensure these tasks were completed in a more holistic way for people.

During our inspection we checked the way medicines were looked after and administered to people. A recent internal audit by the provider had found some issues with the way medicines were looked after in the home. Following this audit some measures were already being put into place to improve medicines management. The supplying pharmacist had been to the home and completed updated training with registered nurses and senior care staff who gave medicines. A new medicines policy had been drawn up and was about to be introduced to staff.

People's medicines were stored in locked cupboards in their rooms. Some people looked after their own medicines, after it had been assessed as safe for them to do this. Other people had their medicines given to them by registered nurses or senior care staff who had received training and been regularly checked to make sure they gave medicines safely.

Other medicines were stored securely in locked rooms and cupboards, and temperatures were monitored to make sure medicines were stored at the correct temperatures so they would be safe and effective. A second refrigerator that had been received into the home a few days earlier had no temperature records being kept

yet, however the thermometer showed that temperatures were within the required range and the registered manager put this in place immediately. There were suitable arrangements for storing and recording medicines requiring extra security. Staff on the residential units told us these medicines were checked and audited every month, but these checks were not recorded in the register. Staff on the nursing unit told us they checked the balances when items were received or given, but that complete stock and balance audits were not completed. We saw that some non-prescription medicines were held so that staff could respond to people's minor symptoms in a timely way. However we found several of these preparations were passed their expiry date, or had been kept longer than recommended after opening. Two doses of one of these medicines was recorded as given after the 'discard after opening' date.

The morning round took a long time and there was only a short gap before the lunchtime medicine round was due to start. This could lead to the risk of some people being given their doses of medicines too close together, or having to miss some doses because there wasn't enough time to fit them all in safely during the day. We were told that staff were aware of which people needed their medicines first due to multiple daily doses being needed, so they could be sure there was a safe gap between doses. However, we saw one medicine being given after breakfast, where the prescribing instructions said it was to be given in the morning 'at least 30 minutes before breakfast'. Staff on other units told us that medicines rounds were often rushed, as staff were also providing care on these units and were frequently interrupted.

We looked at two people's care plans to check for guidance on their medicines. One person's records were not clear about whether they were receiving their medicine covertly (without their knowledge). There was a mental capacity assessment that recorded they did not have the capacity to make decisions about their care, but no 'best interest' decision was recorded about which medicines may need to be given covertly, or how this would be done. The care plan stated that it was important that this person received their anti-depressants regularly.

Another person was prescribed a sedative medicine to be given three times a day. However we saw from their current medicine administration chart (MAR) that it was only being given when needed, usually once a day. It was recorded in their care plan that it was to be given 'when needed' but there was no protocol or guidance for this person as to when it would appropriate to give this medicine. This was not in line with the medicines policy for the home, and meant this person might not always get their medicine in the intended way. Staff were able to tell us when it would be appropriate, but any agency staff would not be able to find this information from their records.

This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We watched some medicines being given to people during the morning on the nursing units. Medicines were given and recorded by a safe method and in a caring way. People were asked if they needed any 'when required' medicines such as pain relief. We checked 17 people's MAR charts. Charts were completed when medicines were given, or reasons recorded if doses were omitted. Care staff recorded the applications of creams or other external preparations on separate charts, with clear body maps showing where topical creams were required. Records were kept of medicines received into the home and those sent for disposal, which helped to check how medicines were looked after in the home. Monthly audits were completed by staff, however these had not picked up some of the issues that we found, such as out of date non-prescription medicines being held.

There were policies and procedures in place to guide staff, and these were currently being updated. Information about medicines was available for staff and residents.

There were systems in place to protect people from the risk of abuse and avoidable harm. All of the staff knew the different types of abuse that could occur and told us they would not hesitate to report any concerns they had to senior staff. The home did not care for any people with behaviour that could be particularly challenging for staff and there had been no incidents of altercations between people living with dementia at the home, for example. The registered manager had also ensured staff were safe and there was a plan relating to one person to always have two care workers present to reduce unsubstantiated accusations. Staff added they would also report any concerns outside of the home if they felt this was appropriate. Staff and the registered manager understood the correct reporting procedures and we saw these had been followed when necessary using the local authority safeguarding process.

Risks to people's safety had been assessed and actions taken where necessary to mitigate these risks, although due to the staffing levels these were not always effective. Care plans included clear identified risks in relation to falls, not eating and drinking, developing skin pressure damage and social isolation. There was clear information within people's care records providing staff with guidance on how to reduce these risks. Staff were clear that the least restrictive method was sought and regularly reviewed. Staff were able to demonstrate they understood these risks and what they needed to do to keep people safe but struggled with having enough time to supervise people. Staff told us the importance of making sure the environment was safe and clear of any obstacles when people were walking around the home. This was to protect them from the risk of falls and also to maximise independence.

In respect of the premises, we saw that fire doors were kept closed and the emergency exits were well sign posted. They were clear of any obstacles so that people could easily reach the exits if needed. Testing of the fire equipment and the fire alarm system had taken place regularly. Staff demonstrated to us that they knew what action to take in the event of an emergency such as a fire or when someone became unwell. They confirmed that they had received training within these areas. Each person had a personal protection evacuation plan (PEEP) giving staff and the fire brigade easy access to important information about individuals. The equipment that people used such as hoists including slings had been regularly checked and serviced in line with the relevant regulations to make sure it was safe to use. Any accidents or incidents that took place were recorded by the staff and investigated by the registered manager. We saw action had been taken when any accidents or incidents had occurred to prevent reoccurrence.

Staff files showed that the relevant checks had taken place before a staff member commenced their employment. This included criminal record checks (DBS), gaps in employment and the service asked for at least two references including previous employer. This was to make sure potential new staff were safe to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we rated this area as requiring improvement. This was because people's rights were not protected, because the service did not always act in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment. At this inspection we found the registered manager had addressed this issue. There had also been a risk that people's medical needs may not be met because of ineffective communication between staff and health professionals. Systems were now in place to ensure effective communication. People at that time were at risk of receiving a service from staff who were not appropriately trained. Extensive training had since been undertaken to ensure all staff were up to date.

During this inspection we found the service was not always effective due to the lack of staff. This meant that although personal care needs in the morning were completed, people could not be secure knowing that if they rang their call bell it would be answered in time to prevent incontinence, ensure people were comfortable or notice if someone was unable to ring the call bell required assistance. Management had not recognised that people were not receiving consistently effective care in relation to their level of need or acted in a timely way to ensure this was happening. Staff talked to us about the support and supervision they received. They said they felt well supported within the home and that there was always someone to go to for advice. However, they had been raising the issue of low staffing levels for some time. In staff meetings the topic was raised and accepted as an issue but staff were told to move forward and work as a team with senior shift leaders for support. A senior had again said they needed at least two further care staff and the response in the minutes was that the business plan had gone forward for one care worker with a start date of April. From our findings this was not adequate to ensure effective care.

Despite the lack of appropriate staffing levels, especially on the residential units, we found people's health needs were well met. Very few people had skin pressure damage despite a high level of risk identified. Referrals to district nurses had been made appropriately to manage any wounds, which were healing well. The home was using a high level of agency staff as they continued recruiting new care staff. For example, 12 agency staff had worked shifts over the previous weekend as seen in the agency signing in book. At the last inspection we had found agency staff did not have access to sufficient information about each person's care needs. At this inspection we found they had addressed this by providing easy to read summaries of people's care needs in an accessible place in each person's room. We asked agency staff how they knew people's and they told us they were given a handover before going to the units, and then received a good handover from staff on duty. They also referred to the care plans in people's rooms, and could ask the home's staff if they were uncertain about anything. They told us the staff were very approachable and always answered their questions fully. The deputy manager explained that, on arrival, agency staff received an update from the shift leader on the day's happenings at the home generally, and were informed of their allocated duties for their shift (such as delivering meal trays). Also, if it was their first shift, the shift leader would carry out their orientation and induction. Then, on arrival on the units, agency staff would receive a handover from departing staff about the individuals they would be supporting. This would include such things as requests from people to be actioned during the coming shift (such as someone wanting to go somewhere or attend an appointment), or who was still drinking their tea/coffee so this could be monitored. The registered

manager said they met weekly with the agency provider to discuss any issues and used regular agency staff for consistency.

People sometimes received effective care based on best practice from staff who had the knowledge and skills required to enable them to carry out their roles. The lack of staff meant they did not always have time to respond to people's needs throughout the day. However, people all said they felt the staff were well trained. They felt staff were busy but always knew their needs and how to care for them, including agency staff. There was a new visiting health professionals communication book which was well used and contained detailed information about people and their changing health needs. People told us about individual care staff saying, "They know everything." Health needs such as a possible urine infection or sore area were identified and well managed in a timely way, including chasing up on any tests and ensuring medication was obtained. We did not see any evidence that pressure damage had occurred due to prolonged incontinence or delay in moving and handling but this remained a risk.

Permanent staff felt they had received enough training to provide people with effective care. Agency staff received training from their agency and their competency was monitored. A new in-house trainer role had been created and training the provider felt all staff needed to do was up to date. Staff competency to do their role was regularly assessed and staff received clear and constructive feedback to enable them to improve their practice when necessary. The senior shift leader was very knowledgeable as were all staff who were able to tell us in detail about how they were to meet people's needs. Team meetings were held regularly in all units. Staff training needs were on each agenda and within supervisions and there was opportunity for staff to make suggestions and have an input. For example, a plan was in place to support a staff member with a particular condition to ensure they were working in the right environment for them to be effective. The registered manager also held 'flash' meeting in groups to address any gaps in clinical knowledge that arose. Staff 'surgeries' were held three monthly where the provider's human resources (HR) manager met with staff. Staff could ask HR questions and other work related issues. Agency staff were supported by a permanent staff member 'buddy' system. The provider also held a Wellbeing' launch where staff could access health and wellbeing benefits. This had helped with maintaining retention of skilled staff over the last year and improving staff consistency for people.

New staff received a comprehensive induction followed by at least a week shadowing more experienced staff. Staff had completed training in a number of different subjects such as safeguarding adults, dementia, medicine management, tissue viability, nutrition and hydration. They said they were given lots of opportunities to attend training in areas that reflected the needs of the people who lived at Cadogan Court and the level of staffing in place during our inspection was maintained to enable this. Staff had achieved national vocational qualifications (NVQ) or were working towards 'Care Certificates'. These are a set of recognised standards that health workers are expected to follow in their daily working life to provide safe, compassionate care.

People were supported to maintain good health and had access to healthcare services as necessary. People were referred in a timely way and saw healthcare professionals such as their GP, dentist, optician or chiropodist when they needed. If people chose to access health care appointments independently this was arranged. Extra staff were booked in to chaperone external health appointments. For example, a person admitted with skin pressure damage had been well managed with local tissue viability team input.

Staff within the seven units had developed excellent relationships with community specialists. This included the local GP who was pleased with the health care people received. They said of the senior shift leader at the time of the inspection, "She is very good indeed, completely on the ball." The GP completed weekly rounds at the home and staff kept a list of who needed referrals. People could also choose which GP they registered

with if they wished. The registered manager explained the service had had to establish new GP and community nursing services for all residents in the last year, which had been difficult but was now resolved. Community nurses now came on two days each week. The healthcare professionals we spoke with told us the staff were very knowledgeable and always referred people to them in a timely way if they had any concerns about their health needs. They told us staff noticed deterioration in their health and acted accordingly to help them. The GP we spoke with had been visiting people at the home for a few months. They thought the new management had brought more certainty and that communication was effective (explaining that in the past there had been a lot of communication, but it had not always been effective). They gave specific examples of good communication such as about warfarin (a medication which requires close blood level monitoring), which was now done in writing rather than by phone and about requested blood glucose (sugar) measurements, which staff had not only done but reported back to the GPs. The GP notes in one care plan file showed how pain relief had been discussed and prescribed following a fall, and a request for a medicines review. The person's care plan included the pain relief the person had been prescribed, showing staff had reviewed and updated the care plan. One person told us staff had noticed before they had, that they had a serious chest infection developing and arranged medical attention. They told us they knew they could see a dentist or optician if they wanted to. They said they would not hesitate to call for help if they wanted it and it was no trouble for staff when they came.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA).The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. This had been an issue at the last inspection in July 2016, where restrictive measures had not included discussion about best interest decisions. This was now done. 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 are called the Deprivation of Liberty Safeguards (DoLS). Staff clearly understood the importance of seeking people's consent and offering them choice about the care they received. Where people lacked capacity to make some decisions, the staff were clear about their responsibilities to follow the principles of the MCA when making decisions for people in their best interests.

Staff gave us clear examples and records showed how they supported people to make decisions. We observed staff asking for people's consent throughout the inspection. For example, showing simple choices of menu, clothes and drinks. Records showed that people's ability to consent to certain decisions had been assessed and best interest decisions made. These had involved the relevant individuals such as the person's family or a healthcare professional. There was clear information within these records to give staff guidance on how they needed to support people to make a number of different decisions about their daily lives. For example, bed rails and pressure alarm mats were used appropriately and use was reviewed regularly.

People received support with eating and drinking and to maintain a balanced diet. People we spoke with and visiting relatives told us the food was of a good quality. A list of likes and dislikes was completed on a person's admission and added to as staff got to know them. There was also a list of people's dietary requirements, documenting food consistencies required, for example normal, pureed, thickened fluids and fork mash-able. People who required more regular monitoring, for example of their nutritional input, had food and fluid charts. We saw people were assisted to maintain adequate input, however charts did not show optimal levels of input and were not totalled. We fed this back to the registered manager.

Meals were cooked freshly in the kitchen and plated up as individuals liked it. Catering staff knew who was on which diet such as diabetic or soft. We took lunch with the 32 people in the main dining room. People

were reminded of the menu when they sat down. There was a good choice and alternative. There was a meat and fish option for example during our inspection and a good choice of desserts. Staff used a sign on the table to indicate which table had been served first and rotated it around the room each meal. The evening meal menu also included a good choice and hot options. Meal time was a very social and enjoyable occasion. The meal was served by a 'waiting' team, who were very attentive, kind and knew people well. Nothing was too much trouble, one person asked for a different cream which they got immediately. They told us they loved their jobs, which we could see. One staff member said how well they worked as a team. They had worked there for 27 years and enjoyed the convivial atmosphere. They all said what a great manager the operations (catering) manager was. People were encouraged to use the dining rooms but could eat wherever they pleased. Individual trays were picked up by care staff for people who required assistance on the units.

Meals were served at pretty, laid tables with condiments, fresh flowers and a choice of fruit juices. A 'lazy susan' spinning centre piece enabled people to reach what they needed. Lots of people commented that spring was here with the daffodils on the tables. Tea and coffee was offered after the meal. There was also a selection of wines and fresh fruit available. Lots of people took some fruit from the large fruit bowl to have later. The operations manager was clearly passionate about their role for many years and took pride in their work, instilling this person centred ethos into their team. They ensured they regularly asked for people's feedback to inform menus and put on themed nights and some people had had a 'pub lunch' in the unit 'pub' to watch the recent rugby. People said they were "well fed".

Care records for people included a 'malnutrition risk assessment', which were completed monthly. One showed that the person's weight varied over time. Recently, staff had noted the person had lost a more marked amount of weight and a food diary was commenced. The next month, records showed the person had regained some weight.

The home was large and set out over three floors with a light, spacious reception area with an attractive fish tank which able people were enjoying. Plants in communal areas were flourishing and looked cared for. There was a hot drinks machine and biscuits available for people and visitors. The environment was well maintained although attention could be paid to reducing the institutional feel, with notice boards showing clinical information, care check files being kept outside people's doors and a lack of homely decoration in the corridors. The registered manager said further decoration was part of the service improvement plan and there were projects underway with the local college to include murals and decoration of interest to help people orientate between the units. Currently the units looked very similar. We saw a vacated bedroom was being repainted and refurbished, which staff told us was standard practice.

There was a wide range of suitable equipment available such as adapted baths, specialist chairs and wetrooms so that people with physical disabilities could access baths or showers. There were hair-washing sinks in some bathrooms, with the home also having a hairdressing salon for men and women. Some bedrooms and bathrooms had ceiling hoists, which senior staff told us were installed if individuals required them. Bedrooms had wider doors, making it easier for people with wider wheelchairs to get in/out of their room for example. Dining chairs had gliders to promote independent or easier movement. Corridors had handrails on both sides. This meant people with a one-sided body weakness, such as after a stroke when the left or right side might be weakened, had equal opportunity to walk about whichever side was affected.

On Alford, the unit specifically for people diagnosed with dementia as a primary diagnosis had different colours to assist people living with memory loss and dementia. For example, doors were painted in contrast to walls, with bedroom doors having painted features of a front door distinguishing them from bathroom doors for example. Toilet seats were in contrasting colour to the surroundings to promote independent

continence management. Picture signage was used to identify different rooms, such as a photograph of a plate of food on 'dining room' signs. We suggested that thought could be given to using these methods in other units within the home where people living with dementia were also cared for. Currently staff used photos of people on their doors to identify people's rooms. We discussed this method of orientation with the registered manager as people living with dementia do not always recognise their current self. The registered manager said they were looking into providing memory boxes outside rooms as a more person centred way for people to find their rooms and to aid staff facilitate conversations about things people liked. Some rooms had notices on, with people's permission, stating if they were hard of hearing or partially sighted to remind staff to use appropriate communication methods, which was effective but not used throughout the wider home, which could be helpful.

Requires Improvement

Is the service caring?

Our findings

Without exception, people and visiting relatives told us the staff were extremely caring, compassionate, attentive and dedicated in their approach but there were not enough of them to give people time. We found all staff were kind, caring and dedicated throughout the inspection, aiming to do the best they could for people, whom they knew well. The lack of care staff impacted on how much time staff had to spend with people or supervise how people were. One staff member said, "We really care about good standards, you can't do this job if you don't care. I don't like to see people having to wait [for assistance with their meal]." Staff were also caring to each other. One staff member said, "[The operations manager] is the best manager. He is so kind and supported me with personal issues in an amazing way to make sure I was ok."

We did note that staff worked hard with the resources they had to ensure tasks such as personal care and receiving food and drink were completed in a timely way. A visiting GP told us staff were usually available to assist them to see people, as we saw during our visit. In their view, staff did not rush people if at all possible. Staff all said they made sure they completed personal care such as assisting people to wash and applying topical creams. People had good skin care and oral care, for example and details such as making sure people's hair and nails were done as they liked them were completed. People were well kempt and looked well cared for.

However, there were examples during our inspection of how some people's dignity was not maintained. We saw one person was sat with the door open with their trousers round their hips showing their bottom and slipping out of the chair so we asked staff to assist. There was an uncovered used commode beside them. One staff member went to assist although this person's daughter had told us they required two staff to hoist them.

Another person called to us from their room. They were concerned that their commode was not by them. We suggested they ring their call bell to speak with staff as none were seen in the area. Where people were displaying anxious behaviour, staff were not visible to notice and support them.

One person at the end of their life rang the bell often and was very anxious, no staff had time to sit with them to reassure them, just kept going in and turning off the bell. However, they were kind and spoke gently to the person whilst they were there. Staff said and we saw that care workers had no time to spend with people other than for tasks. Information about people's end of life care needs was sometimes lacking. One plan only contained that the person had a treatment escalation plan (TEP) in case of a cardiac arrest, for example. A person's care plan, who had recently lost a loved one who had also been living at the home, did not include their bereavement or how to manage this. Other examples were around the inability of staff to always support people with maintaining their continence in a timely way resulting in undignified events.

This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans gave good information to people about what the care plan was for and were involved in their

regular reviews ensuring that they had input into the way they preferred their care. Relatives said they were always contacted and informed of any changes. They spoke highly of the registered manager and staff team saying they felt they could be involved as much as they could or was necessary.

People were addressed by the staff using their preferred names and the staff knocked on people's doors before entering into their room. When personal care was being given, the staff made sure that the doors to people's rooms remained closed or prompted people to remember to close their doors. Staff were respectful when they assisted people with eating and drinking. One staff member noticed when a person had not got their dentures in and went to find them discreetly. Staff sat at eye level and spent time with people individually giving then their full attention and chatting. They asked people if they had had enough food, if they would like seconds and waited until people were ready before offering another mouthful telling the person what was coming. No-one had anything negative to say about the staff, although they looked forward to a reduction in the level of agency staff following recruitment. They thought the agency staff were all nice and helped them in a respectful, knowing way despite sometimes not having met them before. Permanent staff wore large, easy to read name badges stating their name and role and people talked to us about care workers by name, having built relationships with them. When people had enjoyed an activity such as winning a bingo prize, all the staff knew about it and congratulated the person making them feel special.

People were surrounded by items within their rooms that were important and meaningful to them and staff looked after their belongings and laundry respectfully.

We observed throughout the day that people could make decisions about how they wanted to be cared for. This included areas such as making choices what they would like to wear, where they ate and what they wanted to eat. People were actively involved in making decisions about their personal care on a day to day basis and staff knew what people's preferences were. Relatives told us they were encouraged to visit their family member regularly and to be involved in their care. They said they were always made to feel extremely welcome, appreciated the hot drinks machine in the reception and ability to help themselves to drinks and that the staff kept them fully informed about their relatives health and wellbeing which was very important to them. They had access to Cadogan Court newsletter and the provider RMBI News to inform them of what was happening in the service.

Residents and relatives meetings, took place regularly to obtain peoples' and relatives' views on the care provided. There had recently been an informal open social meeting where people and relatives could enjoy some food and meet staff including management. A regular newsletter was also sent out detailing events, a quiz, poetry and reminiscence about a particular year in each edition.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in July 2017 we rated this area as good. People then received care that was responsive to their needs and personalised to their wishes and preferences and people could choose to participate in organised activities and were supported to organise their own activities if they wanted to. At this inspection we found this was not the case .

Although the service was responsive to changes in people's health needs in a timely way, the lack of care staff meant that people did not receive always person centred care. The care plans were currently paper based (with plans to computerise soon) and very comprehensive, however senior staff had not always had enough time to fully keep them up to date. The staff were aware of this and doing their best to set time aside, saying they only had time to update two or three a month. One care plan needing updating about a person's new way of communicating for example. One senior staff member was booked to work a full supernumerary day doing administration work, although forfeiting a day off which does not show good management. They felt that with extra care staff this task would be able to be completed in a timely way ensuring staff followed up to date care from the care plans, especially as the home were using a high level of agency staff during their recruitment period. At present staff relied on detailed handovers and verbal communication, which could be a risk and permanent staff felt more staff were needed 'now'.

Care plans contained good person centred information for staff to follow to be able to give person centred care but some plans were not up to date, including the care plan summaries kept discreetly in people's rooms. For example, one person was recently bereaved, their spouse had been living at the home. The care plan and summary did not include this or how staff should approach the subject. However, permanent staff were aware and knew that the person, despite living with dementia had some insight and staff were talking to them about it during tasks. They had verbally informed agency staff who were aware but this was not good practice as there remained a risk that agency staff may not be given this information. There was no other time though for staff to provide specific support and conversation, although their activity record said they would need company due to their bereavement. Another person had had a traumatic past and was being checked by staff every 30 minutes as the person preferred to stay in their room. However, due to time restraints this check had become a staff member quickly opening their door and saying 'alright' and signing to say checked, without any further conversation. The person told us they found this raised their anxiety and they would like to have a chat now and again. They were clearly distressed when talking to us. They had requested no checks at night which was documented but still the checks had been done, waking them up so they had to get up and sit in their chair due to their insomnia. Their care plan said the person needed regular support with mental health issues, which was not happening. We fed this back to the registered manager informing them of a particular staff member the person got on well with. On the second inspection visit staff had been able to facilitate a family visit and persuade the person to venture out of their room. The person said, "If I need a new pad, I try and call and eventually staff will come. I spend all day and no-one talks to me, they just pop their head in the door." This had resulted in them rejecting any interaction and staying in their room.

Staff clearly knew what person centred care was and were anxious to give it. One person required staff to

facilitate them mobilising regularly to maintain their mobility. One care worker told us how they didn't always have time to do this and they tried to fit it in before lunch when assisting the person to the toilet for five minutes. They said, "I try to fit it in and find time." A senior care worker said how they worried about people losing their mobility and had felt like leaving. Another care worker had recognised that two people had similar interests and would like to introduce them to each other but had not had time.

Staff clearly cared for people and all were knowledgeable about people's needs as detailed in individual care plans, including domestic and catering staff. Despite the lack of time staff had managed to keep a calm atmosphere within the home. A visiting health professional said, "It's a lovely home with lovely staff. People are well cared for and clean. There is a nice comfortable feeling here, people seem calm." During lunch catering staff were very attentive in their role, chatting to people about topics they were interested in, asking about families or recent events and were able to tell us all about people's lunch preferences.

Care plans followed a comprehensive format with an extensive index including morning, afternoon and evening summaries of care, supporting relationships, strengths and abilities to maintain and improve and life history. There were personalised details about how people's needs such as eating and drinking, mobility, continence (including completed health professional assessments), pain control, pressure area care and risks. For example, "I need two carers to help me get up and I like to lie in after my breakfast", which is what this person was doing. They gave us a 'thumbs up' eating their second 'later' breakfast. Care plans noted when people required prompting with drinks if they were at risk of urine infections. Fluid charts showed this was happening. If people were more mobile and were looking for a drink there were not always sufficient staff to assist. We helped one person get a hot drink as they were looking for staff and appeared confused. One person at end of life was physically being cared for well, being moved regularly to prevent skin damage and assistance gently by kind staff with small ammounts of food and fluid. However, they used the call bell often and were clearly anxious.

Although there were two activity co-ordinators and opportunity for people to attend external entertainment opportunities we found that some people were not facilitated to maintain regular social stimulation in a person centred way to maintain wellbeing. During our inspection some individuals were left for long periods alone and staff did not have time to spend with people or to have input into activities and social stimulation. The activity co-ordinators were employed for 52 hours per week to meet the needs of 70 people. They worked hard to provide as many activities and opportunities within their time limit. Staff also offered to purchase items from local shops if people wished. There were records of interesting and enjoyable activities such as a visit from a birds of prey team, topical sport and bank holiday events, aromatherapy, tea party, crafts, entertainers and bingo. As the home is a masonic organisation there were also lodge meetings and a Friends of Cadogan group who did fundraising. However, individual records showed large gaps of days between attended activities and engagement and many records were family visits. A person with mental health issues had no recorded input since 2 February 2017. Where people refused an offered activity there was no alternative. One person's care plan said they liked to chat to staff but this had only happened once since the 10th February 2017. Another person had enjoyed gardening on 19th February but as they had declined activities from the activity programme, they had no further engagement until 2nd March.

Care staff told us they did not get involved in activities on a regular basis and we did not see this other than on Alford where a care worker was helping four people play a game. People had little contact with care staff other than for tasks and some people with more complex needs such as living with dementia or other mental health needs were not consistently supported. Staff were unable to be pro-active in ensuring care was based on people's preferences and interests, seek out activities in the wider community and consistently help people live a fulfilled life, individually and in groups. All staff said they would love to spend time with people or introduce them to other people living there. One care plan said, "I don't like going to

activities but I do like a chat with staff". There was no daily record note of this happening.

The environment was laid out well over three floors with many different areas depending on what people wanted. The premises was well maintained, bright and airy and a pleasant place to be, especially the welcoming reception and communal main dining room. People could access all areas freely, if able. For example, there was a large circular, open air courtyard surrounded by glass large in the centre. The various corridors of the seven units spanned out from a circular interior walkway with many seating areas. The home was very quiet, despite a lot of communal areas these were generally all empty apart from the two activity sessions. Although the exercise and poetry sessions were well delivered by external professionals, only five people were participating in the exercises with one person asleep. The poetry session had four people participating with one person asleep. There were no care staff to facilitate or brighten the atmosphere, therefore there was little interaction and lack of staff may have affected the amount of people assisted to attend. Two of the five at the exercise class had arrived whilst the session was in progress. During the rest of the day most people spent the day in their rooms with the doors shut. People who were more able did use the reception area for reading newspapers and chatting.

We saw no engagement with people who spent most of their time in their rooms, alone. People who were more able had more engagement as they could move around, read newspapers and do what they wanted but people who were unable to tell us about their experiences spent long periods alone. One person cried when we sat and chatted with them. They were used to living and working with male staff. They did not want to engage in activities with female care workers but would like some engagement, which was not happening. They said they were asked if they would like to go out but they felt they did not want to take staff away from the unit as they were so busy.

On one of the wings intended for people living with dementia, there was a room set up as a pub, with one corner set up as a garden shed, which was creative. Although we did not see people using this room, a staff member showed us some bulbs in the 'shed' she said she had planted with a couple of people, appreciating their gardening knowledge. We also saw a replica launderette area in a lounge and household chores ready for people living with dementia to engage with but we saw no-one in this room throughout our visits. There was a train compartment in a corridor, with two seats and a moving 'view' projected on the 'window', which could be used to engage people. No-one was using these when we were present and staff said they did not use it. There was an unplugged electric keyboard and seat in a corridor, which was available, in theory, for people to use.

This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did have plans for physical improvements such as more interesting wall décor and defining spaces better. A small lounge was to be made into a sensory room. This was planned using research of dementia friendly environment projects and would include interactive tables with computer generated scenes and games, reminiscence scents, seasonal affective disorder (SAD) lighting. We saw lounges on Osborne and Alford had easily accessible activities equipment (specialist dolls for people to carry, which is known to be effective for people living with dementia), colouring items and a 'ball darts' game. A staff member was engaging three people in an activity in the lounge on Alford on the first day and the meal times were sociable, lively occasions. On the second day of the inspection five people were enjoying a mobile shoe shop and were trying on shoes. Senior staff told us there were plans to develop the garden to make it more interesting for people to use but the garden was currently well presented and maintained. There was also level access to a secure garden area. A level area outside Alford, where people could sit or walk, had an impact-absorbing safety surface.

Before people moved to the service they were offered a trial day/lunch and time in the home. The registered manager was mindful about how people moving to the home would affect other people. For example, if someone liked low noise and their own space this was taken into account. The registered manager or senior staff completed all pre-assessments before people moved in to ensure they could meet people's needs in theory.

People and their relatives did not have any complaints about the care being provided other than about the lack of care staff. They knew about the complaints policy and open door office. People and relatives told us they felt comfortable to raise a complaint if they needed to and that they felt confident these would be listened to and dealt with. We were therefore satisfied that people's concerns and complaints were dealt with appropriately in a timely way that promoted learning and improvement. For example, ensuring a curtain pole was replaced immediately and sorting people's post into bills for relatives and other post straight to people as suggested by a relative.

Inadequate

Is the service well-led?

Our findings

At the last inspection in July 2017 we rated this area as requiring improvement. This was because the home had been without a registered manager for five months, and at the time of the inspection was managed by the current registered manager who at that time was newly registered with the Care Quality Commission. At that inspection staff told us the previous manager had "not been there very much", and there had been little improvement in the service over an 18 month period. The provider and new registered manager had identified where improvements were needed and developed a comprehensive service improvement plan. However, whilst we were confident that the provider had recognised the failings and put in place actions to address them, previous systems had not been successful in maintaining the quality of service provision. At that time it was
therefore not yet possible to determine whether these actions would be effective in keeping people safe and improving the quality of support provided. Therefore, at that time some aspects of the service were not well led as there had been no leadership at the home for some time which
had impacted on the quality of the service.

Although the above issues had now been addressed and the service improvement plan was on-going, we found that systems in place did not ensure the concerns found at this inspection had been identified and actioned effectively.

Although an open and transparent culture was encouraged within the home that promoted treating people as individuals, staff felt frustrated at the lack of care staff that was clearly impacting on the quality of people's care. The areas identified by CQC in the previous report had been addressed but this had not included recognising and addressing adequate staffing levels, although dependency level tools were being completed. Whilst the registered manager had listened to staff and put forward a proposal for additional staff, this had not been based on the level of people's current needs and physical tasks that were required, which staff said they had told management about. The registered manager had informed the provider they required extra care staff and was following the provider process but this had not reflected the current needs of people living at the service. One extra care worker had been promised by April 2017 which was not satisfactory to meet people's needs. The issue of a lack of staff had been raised repeatedly by staff and within a safeguarding process in November 2016 where a provider representative had attended. Therefore the issue had been known for some time. The registered manager was currently completing new dependency levels tools relating to people's individual level of need but these had not yet been used in practice and there had not been any assessment of the care delivery in practice on the units, despite provider quality assurance visits. The concerns had easily been identified by CQC by spending one day on the units yet the process being followed by management and the provider to increase staffing levels was not ensuring people's needs were met during this time. This means that systems had failed people in recognising they were at risk and some people were consistently receiving poor care that did not meet their needs.

Despite regular medication audits and a history of increased medication errors, the systems had not identified the issues we found. For example, the length of time medication rounds took which affected the

timing of medication administration, information about 'as required' medication and use of out of date homely remedies.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since we fed back our concerns on the first day of inspection to the registered manager and provider's nominated individual they were quick to respond to the issue of low staffing levels, immediately increasing care workers to two on each residential unit. However, if we had not inspected the service, only one extra care worker would have been introduced. The registered manager said they saw the outcome in a positive way and were keen to make the required changes as soon as possible. The registered manager on the third day told us a clinical lead nursing post and another extra care worker on the dementia unit had also been approved which should improve the issues we found. The registered manager had begun time and motion studies on the work being done by ancilliary staff and those delivering personal care on the units to further ensure people's needs were met in a more person centred way. They were also re-introducing care champions, a role where a staff member would act as link and leader in subjects such as medication, dementia and infection control. The provider pharmacy specialist visited the home just after our inspection to ensure issues were dealt with immediately. Two additional training sessions had been booked and competency assessments and review of the medication policy was taking place. Audits of medication errors showed a decrease and there were comprehensive records evaluating any errors and appropriate actions were taken to reduce future risk.

There had been changes within the home in the managerial team in the last year. The registered manager and team had worked hard to address all the issues raised at the last inspection. There was a new deputy manager and in-house trainer, both very recent posts. The provider nominated individual and managing director had also changed recently. The registered manager felt well supported by the managing director directly and the provider nominated individual following our feedback. On the second day of our inspection staff came to tell us how much better the atmosphere and ability to do their job was with extra staff. The registered manager said, "The whole place had lifted and the domestic team are happy as we have changed the tasks of bed making back to a more holistic approach with the care workers doing this." They wanted to 'get it right' and since their appointment had made good links with the local college, hospice teams, community health professionals improving effective communication and projects were in progress such as the new sensory room, mural art projects and memory boxes. They completed spot checks at night to support night staff and the deputy manager did 'walk arounds' five days a week.

The local social services quality assurance and improvement officer working with Cadogan Court told us the registered manager had been fully engaged with the quality and assurance improvement team (QAIT) and was committed to making the improvements required. However, the QAIT team had mainly looked at care record audits, capacity assessments and the best interest decision making process. Their report said the registered manager had told them safe staffing levels were maintained, with agency staff filling vacancies in the rota as per the dependency tool. However, clearly the dependency tool was ineffective. In a second report the registered manager said they did not think the dependency tool was being used accurately to reflect the needs of the people at Cadogan Court but was confident the staffing levels were safely meeting people's needs. However, there had been no action taken to ensure this was the case. With QAIT, the registered manager had developed the service improvement plan (SIP) to ensure it would be used effectively to log issues identified, to keep track of the actions and regularly review the progress being made against the SIP. The SIP assessed by the registered manager rated the staffing levels as green and 'actioned' with a target for completion as ongoing and immediate because agency staff were used and current levels were maintained but it was not recognised these were inadequate. The registered manager was keen to develop

links in the local area and had been seeking support from a variety of sources such as Devon County Council (DCC) workforce development advisor for safeguarding adults and the falls prevention team.

People told us they valued the staff and knew the registered manager by name. People, staff and relatives said they thought the management team were good, helpful and accessible. One person who was more able said, "It's so lovely here. I don't use my call bell as I can walk. I like the activities and there's enough for me to do. I can't thank the staff enough." One care worker said, "I love it here. We just get on with it for the people. Management do always cover sickness and really it's a lovely home." An agency worker said, "It's busy but always lovely, that's why I keep coming back." They felt well supported and the registered manager met regularly with the agency provider to ensure agency staff were delivering good care and looked presentable for example. A shift leader said, "The registered manager is very supportive and she tries to address our concerns and will ring head office. She won't let you down. She will even come and work on the unit if an agency carer doesn't turn up. We had emergency cover once to cover the medication rounds. We all really appreciate her." Another care worker said, "The registered manager tries their best with the resources we have. We were pleased to see the extra staff, the handover was more positive and staff were happier. They said, "The atmosphere was noticeable when we got the extra staff, bells were quieter and we can give people more time."

The registered manager's office was close to the main door at Cadogan Court behind the manned reception and they operated an 'open door' policy. This was the case with many people living with dementia, relatives and staff popping in. Care workers said they felt able to pop in at any time. The registered manager was visible and accessible and people, relatives and staff all felt able to discuss issues and talk at any time. Staff wore clear name badges and had smart uniforms so they could be identified. Written acknowledgements written in a thorough and sensitive way were sent promptly to reassure people their concerns were being addressed for example. Communication within the staff team as a whole was considered to be important. For example, the daily head of department meetings (known as '10 at 10') had been well received and had meant that all staff including the kitchen and maintenance staff knew what was happening each day for people such as visits, appointments and meetings. The staff all liked working at the home and felt supported by the management team despite their frustrations. Staff all said the training was good, one care worker commenting, "The training is fantastic, I've learnt so much."

The registered manager and deputy kept up to date with good practice and the home was a member of various provider groups where information was discussed and shared. The registered manager had just become chair of the Exeter registered manager's network and they attended the registered managers' forum. This had not yet translated into ensuring people's needs were met at Cadogan Court. The registered manager had also spoken to a training provider to enable them to devise bespoke training in falls prevention and for local guidance to be included in speech and language training. The management support team attended a variety of conferences and seminars where learning was then shared with the staff team throughout the company exchanging ideas and encouraging focal points. For example, there had recently been was a 'four rooms of change' session to address the management changes to support staff. Changes were discussed with staff through formal open consultation on topics such as keeping 12 hour shifts. Management staff had also undergone experiential learning. This had included a practical session where the team experienced wheelchairs, limited sight goggles, wet pads and assisted feeding to give them a greater understanding of people's insecurities and feelings.

The registered manager recognised that staff felt valued and motivated if they had an interest in a topic and they also encouraged staff to undertake additional training such as national vocation training (NVQ) for example. The deputy manager had a level 5 NVQ and some staff had qualifications in leadership and management. For example, psychomatic testing was now included in the recruitment process to further

ensure good quality staff were employed.

There had been a recent quality assurance survey through the 'MORI Your Care Ratings' system and findings were published in the newsletters. The service had received responses from 23 people living at the home and 39 relatives/advocates. The results showed good satisfaction levels in areas such as quality of care, home comforts, staff and care and choice and having a say. 99% of these people were satisfied overall with the quality of care.

When we discussed people's needs with the management team they knew details about everybody living at the home and about staff and their needs. For example, how to support staff with additional needs and people's preferences and changes in health needs. We were told about the needs of the people we would be sharing lunch with. We were then able to have meaningful conversations with them despite their living with dementia, about their hobbies and where they were from. The registered manager, deputy manager and senior shift leader, for example, were fully involved in the lives of people and staff at the home. For example, they were preparing for an admission who was bringing their pet Siamese cat.

Staff worked well as a team across different staff roles. We observed this throughout the inspection. The staff all worked well together, despite the low staffing levels, for the benefit of people in their care and aimed to treat people and each other with dignity and respect. There was lots of laughter between the staff and they were seen being supportive to each other. For example, the dining room was cleared by 2.15pm with people back where they wanted to be following lunch.

Although the issues in staffing levels and medication administration had not been acted upon in a satisfactory, timely way there were systems in place to monitor all aspects of the care and treatment people received. Audits had been conducted regularly by the service and there was continual oversight by the provider head office, who viewed audits monthly. These had assessed areas such as the cleanliness and safety of the environment, the accuracy of people's care records, falls prevention, people's nutritional needs and the management of people's medicines. The provider also conducted regular quality performance and compliance reviews to make sure the home provided people with the care they required. These followed CQC standards, which were also included in training modules and regulations including involvement and treatment, meeting nutritional needs and cleanliness.

Incidents and accidents were analysed each month so that action could be taken to reduce the risk of people experiencing harm. For example, some people who were at a high risk of falling had equipment to minimise future risk of falls. The registered manager looked for any patterns, locations each month to minimise risk overall. Most falls were unwitnessed and we felt these could be linked to the staffing levels. Any concerns or complaints that had been received were used as an opportunity for learning. This demonstrated that the provider and staff responded to people's feedback to improve the quality of the care they received to enhance their wellbeing.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not always have their social needs met and there was a lack of individualised person centred stimulation and engagement due to a lack of staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People's dignity was not always maintained due to a lack of care staff.

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	There were failings relating to medicines management.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance .

The enforcement action we took:

We have issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing .

The enforcement action we took:

We have issued a warning notice.