The Royal Masonic Benevolent Institution

Cadogan Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 30 June and 1 July 2016 and was unannounced. We carried out our last comprehensive inspection on 8 and 10 July 2014. We found the service was compliant with the standards inspected and no breaches of regulations were found.

Cadogan Court is registered to provide accommodation with nursing and personal care, for up to 70 people. The service is offered to older people, including those who may have support needs due to dementia. At the time of the inspection there were 62 people living at Cadogan Court. The provider is The Royal Masonic Benevolent Institution (RMBI), who provides care for older Freemasons and their families as well as some people in the community.

There was a newly registered manager in post. Like registered providers, registered managers are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home had been without a registered manager for five months, and health professionals told us it had been "without leadership for a long time". This had impacted significantly on the quality of the service. A comprehensive service improvement plan was in place, and actions were being taken to address the failings identified. However, at the time of the inspection it was it was not possible to determine how effective these actions would be in keeping people safe and improving the quality of service provision.

The needs of people in the home varied. Some people had complex nursing needs and remained in bed; some had mental health needs and needed constant support and supervision while others were relatively independent and needed little support. A lot of staff had left, and the home had relied on agency staff to maintain staffing levels for over a year. People, relatives and staff expressed concern that agency staff did not always have the knowledge and skills to meet people's needs safely. In addition, agency staff required additional support, which doubled the workload of the permanent staff. This situation had the greatest impact on people with higher support needs.

People's legal rights were not always 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. In addition some 'blanket' best interest decisions had been made relating to 'all aspects of care', rather than a specific decision, which indicates the MCA was not well understood. Staff training needed to improve to ensure people received a service from staff who were appropriately trained.

People had access to healthcare services for on-going healthcare support, however health and social care professionals did not always know if their recommendations had been shared with staff or acted on due to a breakdown in communication. This meant there was a risk people's healthcare needs would not be met.

Although some care plans were comprehensive and detailed, this was not consistent, which meant they did

not always provide the guidance staff needed to meet people's care needs safely and effectively. This lack of information increased the risks for people, particularly if staff were less familiar with the person, for example when a person without the capacity to understand the risks, refused to be supported by care staff.

Prior to the inspection there had been a significant number of medication errors at the home and people had been put at risk. The registered manager was acting decisively to manage this risk, and the service improvement plan aimed to ensure people's medicines were managed so they received them safely.

The newly registered manager provided strong leadership. A recruitment drive was underway, which would decrease the need to use agency staff. They had introduced clear boundaries and discipline for staff, and were developing clear lines of accountability and responsibility. They were proactive in building a culture of transparency and openness at the home. People, relatives, staff and external professionals had confidence in their ability to 'turn things around'. A member of staff told us, "[Registered manager] is bringing structure and clarity. They have reinforced that we are a good team. We all need to work as a team over the next six months. They are approachable. They listen". The registered manager had taken action to improve staff support and training, and was using increased monitoring and audit processes to identify what was working well and where improvements needed to be made. They were acting to improve information sharing across the staff team and with agency staff, by introducing 'wardrobe' care plans which summarised people's support needs, and ensuring recording, handovers and staff meetings were more responsive and effective. They were also proactive in improving communication with external agencies, building positive working relationships with local GPs, pharmacists, health care specialists, volunteers and community for the benefit of the people living at Cadogan Court.

At the time of the inspection the 'Dementia House', was near completion. This was a separate wing of the home catering for people living with dementia who had more complex support needs.

Staff promoted people's independence and treated them with dignity and respect. One person said," I'm quite contented here, very well looked after". A relative commented, "The permanent staff are 'over' and 'above'. They are amazing, wonderful and compassionate". People were supported to make choices about their day to day lives, such as what to wear and how they wanted to spend their time.

People were supported to maintain ongoing relationships with their families and friends. Relatives told us they were kept informed about the well-being of their family member, and felt able to visit them at any time.

The registered manager encouraged people and their relatives to voice any concerns, either using the provider's complaints process or at one of the regular residents/relatives meetings. Relatives told us about concerns they had raised, and how the registered manager had resolved them. Comments included; "I would raise concerns. They are very approachable" and, "The manager wants to know so they can deal with things".

People's individual nutritional requirements were assessed and they received a diet appropriate to their needs and wishes. The catering staff worked hard to make mealtimes an enjoyable and sociable experience for people. The catering manager told us, "There are not many things that people look forward to more than their food. It's a social event, and we need to make that experience as pleasant as possible".

People could choose to participate in organised activities and were supported to organise their own activities if they wanted to. There was a wide range of activities, organised by activity co-ordinators and external volunteers and organisations. Activities staff worked to involve everybody according to their individual needs and ability to participate.

There were systems in place to make sure the premises and equipment were safe for people.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

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.

Care plans did not consistently provide the guidance staff needed to meet people's care needs safely.

The provider had a range of health and safety policies and procedures to keep people and staff safe.

Is the service effective?

Requires Improvement

The service was not always effective.

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.

There was a risk that people's medical needs may not be met because of ineffective communication between staff and health professionals.

People were at risk of receiving a service from staff who were not appropriately trained.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes.

Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect.

Staff were committed to promoting people's independence and supporting them to make choices.
People and their relatives were supported to maintain strong family relationships.

People's 'end of life' wishes were recorded and reviewed to ensure they remained current.

Is the service responsive?

Good

People received care that was responsive to their needs and personalised to their wishes and preferences

People and their relatives were involved in drawing up and reviewing care plans.

People could choose to participate in organised activities and were supported to organise their own activities if they wanted to

Complaints were dealt with effectively.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

There had been no leadership at the home for some time which had impacted on the quality of the service.

A comprehensive service improvement plan was in place and action was being taken to improve the service.

The provider had a variety of systems in place to monitor the quality of care provided and made changes and improvements in response to findings.

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 checked 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.

The inspection took place on 30 June and 1 July 2016 and was unannounced. The inspection team comprised of one inspector, a specialist advisor with expertise in nursing care, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. We looked at the information we had received from the service including statutory notifications (issues providers are legally required to notify us about) or other enquiries from and about the provider.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

We looked at a range of records related to the running of the service. These included staff rotas, supervision and training records, medicine records and quality monitoring audits.
We looked at the care provided to people, observing how they were supported, looking at six care records and speaking with 11 people to help us understand their experiences. As several people were unable to comment directly on their experience of the service we spent time observing care in the communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We had feedback from five relatives, and spoke with fourteen staff including care staff, nursing staff, the registered manager and a trainer. After the inspection we had feedback from five health and social care professionals who supported people at Cadogan Court

Requires Improvement

Is the service safe?

Our findings

There had not been a manager at the home for five months, and a health professional commented the home had been, "without leadership for a long time". A lot of staff had left and the home had relied on agency staff to maintain staffing levels for over a year. Staff told us, "There aren't enough staff. They need to recruit more staff for continuity and consistency. Some agency are brilliant, some not so much. Sometimes we don't get agency cover in time and then we are left with the staff we have on duty". Other staff members commented, "We are not short staffed, it is not the numbers of staff, it's the staff on duty", and, "It depends who you work with, some are better organised than others".

People, relatives and staff were concerned this situation was impacting on the quality of care being provided and putting people at risk. One person said they had felt unsafe with two particular agency members of staff, "I didn't want them near me, they didn't know how to use the hoist, I didn't feel safe with them". A relative told us, "They don't fully appreciate the needs of more physically dependent people…The competence of the agency staff is in question". They told us agency staff had not known how to turn on their family member's oxygen or empty their catheter bag. They had left the person's frame out of reach, so they were unable to get out of their chair to use the toilet. During the inspection a woman, who was usually supported by female staff, was distressed because intimate personal care had been given by two male members of staff who were strangers to her. The registered manager said an agency member of staff had been working with a new staff member who was not aware this was abusive. This was an oversight because new and agency staff usually worked alongside experienced staff. They provided reassurances that the situation would not happen again.

The registered manager was taking action to minimise the risks related to staffing and keep people safe. They used a dependency tool to ensure adequate staffing levels. They maintained the levels as if the home was full, while deliberately leaving unoccupied rooms empty until the workforce was stable. The difficulties arose because agency staff didn't have the same understanding of people's needs as permanent staff. Permanent staff were therefore called on to support them, which doubled their workload. The registered manager told us, "We have introduced wardrobe care plans that live inside the resident's wardrobe and give a snap shot of specific care needs and likes and dislikes". This meant staff who did not know the person could quickly access a summary of the information they needed to support them. The registered manager used the same agency staff wherever possible to try and maintain some consistency. Staffing rotas had been an 'absolute mess', so the registered manager was developing systems to ensure they were effective and any gaps identified and filled. In addition, an action plan was in place with the aim of reducing the use of agency staff through recruitment and improving retention rates. Twenty three new staff had recently been recruited pending satisfactory pre-employment checks.

In the Provider Information Return (PIR), the registered manager reported there had been 29 errors in the administration of medicines in the 12 months prior to the inspection. They told us the errors had been due to 'staff flippancy'. One person had experienced a severe allergic reaction after being given medicine they were allergic to, even though they were wearing an SOS bracelet warning of this particular allergy. The allergy had not been recorded correctly on their medicine administration records (MAR). A relative expressed

concern because their family member's cardiac medicine had run out. This meant there had been a delay in them receiving it until staff collected some more later in the day.. Two members of staff expressed anxiety about administering medicines. They told us "people were trying to do too much", and, "If you are trying to do medication and personal care when you are on your own mistakes are going to happen". They told us the registered manager had relieved them of this responsibility because they felt so unconfident. Steps were being taken to ensure people's medicines were managed so they received them safely. A service improvement plan was in place and actions included clarity around responsibility for ordering and documenting medicines, retraining and continually assessing staff, ensuring monthly medication audits were completed, with MAR charts checked daily and medication errors were identified quickly with appropriate action taken.

Care records contained risk assessments according to the individual needs of the person, for example related to the risk of falls, pressure area damage, seizures or nutrition. Guidance for staff to manage the risks was then transferred to the care plan. For example one person's risk assessment showed they were at high risk of skin damage. The care plan contained clear instructions for staff on how to support the person and the risks were now minimised. Another person assessed as being at risk of seizures had a clear seizure management plan plus a protocol for the administration of emergency medication if required. However the assessment of risk and guidance for staff was not consistent which meant people were at risk of not receiving safe care. For example there was no guidance to advise staff how to respond when a person without the capacity to understand their risks, refused to be supported by care staff. The care plan of someone with diet controlled type two diabetes, advised the person 'preferred desserts' and that staff should support them to make healthy choices due to diabetes. However, there was no information about how they should do this, and what the person's preferences might be. The registered manager explained the person was new to the home and the care plan would be developed over time, but this did not support staff to manage the risks in the meantime.

The registered manager was aware of these issues and was taking action to address them. A service development plan had identified the need for care plan audits and updates, and a new system had just been introduced where care plans were reviewed regularly by senior staff to check they were accurate. Electronic care planning was due to be introduced in 2016 in line with other RMBI services. Computer terminals would be available for staff to use throughout the home, which would make it easier for them to keep care plans up to date.

The provider had a range of health and safety policies and procedures to keep people and staff safe. Staff had a good understanding of the policy and procedures related to accident and incident reporting. Records were clear and showed appropriate actions had been taken. The registered manager recorded and investigated incidents where required, and took any action needed to prevent a reoccurrence. The information was collated and analysed, allowing the provider to understand any causes and consider additional preventative actions that might be needed to keep people safe. The system had been effective in reducing the high number of falls and injuries within the home, because it had led to the introduction of a range of safety measures. For example training in falls prevention had been provided, people vulnerable to falling were referred for specialist assessment; some people had alarm mats which alerted staff when they attempted to stand on their own, there were staff in communal areas at all times, and call bells ringing for longer than six minutes sounded with the emergency 'bleep' which required staff to respond immediately.

Risks of abuse to people were minimised because the provider ensured all new staff were thoroughly checked to make sure they were suitable to work at the home. Staff recruitment records showed appropriate checks had been undertaken before staff began work, and Disclosure and Barring Service checks (DBS) had been completed. The DBS checks people's criminal history and their suitability to work

with vulnerable people.

People were protected from the risk of abuse through the provision of policies, procedures and staff training. Safeguarding training was mandatory for all staff, whatever their role, and there were plans to appoint a 'safeguarding lead' who would take responsibility for safeguarding at Cadogan Court. Staff knew how to recognise if people were vulnerable to abuse, and how to report any concerns. They were aware of the service's whistleblowing policy and told us they would feel confident to use it. Where allegations or concerns had been bought to the registered manager's attention they had acted to make sure issues were resolved and people were protected. Effective disciplinary procedures were in place.

People were cared for in a clean, hygienic environment. The team of cleaning staff was managed by a domestic supervisor, who monitored the quality of the domestic and laundry services. Daily, weekly and monthly cleaning schedules were maintained. There were effective infection control measures in place. Staff had access to hand washing facilities and carried hand gel. Personal protective equipment (PPE) was provided for all staff,

There were systems in place to make sure the premises and equipment were safe for people. The facilities manager ensured maintenance checks of all equipment and regular services were completed, the building and grounds maintained and any repairs addressed quickly by dedicated maintenance staff.

Staff had received training in fire safety, and fire checks and drills were carried out in accordance with fire regulations. Individual fire risks assessments were in place and each person had a personal emergency evacuation plan (PEEP) showing what support they needed to evacuate the building in the event of a fire.

Requires Improvement

Is the service effective?

Our findings

People's human rights were not being protected under 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. 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. Some people had restrictions in place, such as bed rails or pressure mats, to keep people safe, but the service had not fulfilled its legal responsibilities under the MCA to ensure these restrictions were in their best interests. In addition some 'blanket' best interest decisions had been made relating to 'all aspects of care', rather than a specific decision, which indicates the MCA was not well understood.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

The registered manager was aware of this issue. The service development plan highlighted the need for people to be assessed under MCA as required and staff to be trained. This had not been achieved by the target date, although the registered manager assured us this was in hand. People's rights were being protected in relation to the Deprivation of Liberty Safeguards (DoLS). 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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Several referrals for assessment had been made.

People had access to healthcare services for ongoing healthcare support. There was a weekly GP clinic at the home, and care records showed people were referred appropriately to other professionals, such as the dentist, optician, and chiropodist. Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately. There were however concerns about the passing on of information. For example, one professional said they had been unable to find out from staff whether a person had received a particular medication. They commented on the high number of agency staff, and told us, "Staff are not really invested in what's happening". Another health professional told us they had been unable to find a member of staff to be with them when they were assessing and treating a person at the home. They had found a member of staff afterwards to feed back to, but they had been very busy and they were not confident the detailed information would be passed on.

People were at risk of receiving a service from staff who were not appropriately trained. The training matrix, designed to show which staff had completed training and which staff were due, showed that there had been poor compliance with mandatory training. This covered topics such as moving and handling, infection prevention, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and Equality and Diversity. In addition, staff told us they didn't always have the training they needed to meet people's specific needs, for example related to managing behaviour which was challenging, or working with people who had a head injury.

The provider and registered manager were taking action to ensure staff received the training they needed to support people effectively. The service development plan stated that each member of staff would have a robust training plan. Trained nurses would be supported with their revalidation, requiring them to demonstrate they were practising safely and effectively, and continuing to develop professionally. In the PIR the registered manager stated, "Champions in different health aspects will be chosen and trained up to deliver current best practice. We currently have an infection control champion; we will appoint a tissue viability champion, a dementia champion, a safeguarding champion etc". Funding had been agreed for an 'in-house trainer', who, along with visiting trainers and dedicated members of staff, would provide the training staff needed to support people. All sessions would be face to face, and practical, with no 'e learning'. At the time of the inspection there was a classroom session in progress about fire safety. Further training sessions were planned in other mandatory topics.

New staff completed a comprehensive induction programme tailored to their role and a three month probationary period. They were given a 'buddy', a more experienced member of staff, as they got to know the home, their role and responsibilities and the people they would be supporting. Initial training included, 'promoting dignity', 'providing personal care', and 'eating and drinking'. 'Experiential' training was used to help all new staff understand the importance of person centred care. This included being left on their own in an empty room for 15 minutes without access to a clock or any form of communication, wearing a wet incontinence pad for ten minutes, and having their face and neck washed by a carer. New staff also completed the new Care Certificate. This is a more detailed national training programme and qualification for newly recruited staff. Agency staff completed a brief induction to inform them of their role and responsibilities and familiarise them with the home.

Staff told us they had formal supervision every 12 weeks, and that this supported them in their role. They told us, "We talk about the way residents are being taken care of, and any management issues". In the PIR the registered manager stated, "Staff attend regular supervisions and receive feedback about their performances. This is also used as an opportunity to raise any concerns or issues they may wish to discuss." However, the PIR showed that the majority of staff had not had an appraisal in the last 12 months.

People told us they liked the food and it was of good quality. The home had a food hygiene rating of five. A relative commented, "The dining room is amazing, it's like a posh restaurant!" They told us their family member was, "very pleased with the food, they enjoy it. Their wine is always on the table when they go. They rave about some of the meals and love the social interaction." The catering manager told us, "There are not many things that people look forward to more than their food. It's a social event, and we need to make that experience as pleasant as possible".

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. The head of catering explained the chefs learnt about people's dietary needs on arrival, by reading their initial assessment and talking to them about their preferences. This information was used to develop a dietary profile. The chefs took responsibility for ensuring this remained current and the resident's nutritional needs were met. Information from the speech and language therapist (SALT) advised the chefs when people might be at risk of choking and therefore needed a soft or puree diet. Moulds were used so that such meals were served as the different components of the meal to retain an appetising appearance, rather than being mixed together. Alternative puddings were available for people with diabetes.

People were offered a choice of meals and snacks were available throughout the day. At breakfast time kitchen staff talked to people in the dining room about their choices for the day, and visited people who chose to eat in their rooms. Meetings were held for people to put forward their suggestions for the menu, which was changed twice a year, and there was a book in the dining room inviting people to comment on

the food.

We observed lunchtime in the main dining room and in a smaller dining room where people had more complex support needs. There was a good rapport between staff and residents, and staff were very attentive. However, in the main dining room there were not enough care staff to provide individual support to people needing help to eat their lunch. This meant staff were assisting more than one person at the same time, which some people found difficult. The atmosphere in the smaller dining room was calm with relaxing music playing in the background. While supporting people to eat, staff explained what they were doing and what the food was. They knew people's preferences, even if they could not verbalise them, "I've got you some ice cream. I know you like that". People appeared to be enjoying their meal, eating at a steady pace. Staff did not rush people they were supporting with their food, drinks or when they assisted them from the tables.

Good

Is the service caring?

Our findings

People told us the service was caring, saying the permanent staff were good, kind and respected them and their needs. One person said," I'm quite contented here, very well looked after". A relative commented, "The permanent staff are 'over' and 'above'. They are amazing, wonderful and compassionate". Another relative praised the attentiveness of staff, telling us his family member had mentioned to a carer that they fancied some cheese, "The next time they went to lunch they had a big plate with six cheeses!" A thank you letter from a relative said, "The fact that carers, even those off duty, took the time to come and say happy birthday meant so much to [family member]…They are still talking about it now and how wonderful it was". In the PIR the registered manager stated, "We care deeply about our residents, and about all people who may use our services. Our management team operates an 'open door' policy to ensure they are available to every resident every day. Our Home Managers are visible on the floor and engage with residents and staff. We are committed to person centred care - all resident's needs, preferences and beliefs are respected through our policies, values, culture and behaviour".

We observed and spoke with permanent staff who were respectful, understanding and patient, and sought consent before providing assistance. In the PIR the registered manager stated, "All staff understand that consent to care is vital. It is also an ongoing check – consent can change and must be regularly sought to ensure consent is given, recorded and communicated. This is particularly relevant if any changes occur to the person's care and support needs". Staff were able to tell us about people's complex needs, and how they promoted their independence by supporting them to make choices, for example what to wear. "I would show them different options, and ask them to pick which one they wanted. Sometimes they might not want to go to the dining room for lunch, so I'll bring it to their room". They ensured curtains and doors were closed before supporting people with personal care. The domestic supervisor told us their team operated a 'knock and ask' policy, which meant they didn't enter somebody's bedroom without first knocking, explaining who they were, and asking, "Is it ok for me to clean in here?" A relative was very complimentary about the cleaning staff, telling us, "They are very friendly and discreet, not intrusive. They always ask if it's ok to do the room now".

People were supported to maintain ongoing relationships with their families and friends. Relatives told us they were kept informed about the well-being of their family member, and felt able to visit them at any time. " They are always very good when I ring, and respond quickly." We saw a card from another relative stating, "We truly appreciate…the friendship, support and warm welcome we both received every time we visited them". Some people's families lived a considerable distance away, so visiting for them could be difficult. One such relative told us they had asked the registered manager if it was possible to have an 'overnight' room for visitors who had to travel such long distances. This was being looked into.

People's 'end of life' wishes were documented in their care plans and reviewed to ensure they remained current. In the PIR the registered manager stated, "We discuss end of life care to ensure we understand each resident's wishes. We record this in their care plan and ensure relevant staff are aware of them. Residents are supported in this process should they wish to be". There were plans to create a multi-denominational chapel in the home, which could be used by people and their relatives if they needed a quiet and private

place to sit.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. People were able to make choices about how the service supported aspects of their day to day lives. In the 2015 annual satisfaction survey all of the 17 people who responded agreed they could have visitors when they wanted to and had enough of their own things around them. Ninety four per cent said they could take part in activities/hobbies if they wanted to and 93% said they could choose what time they got up and went to bed.

In the PIR the registered manager stated, "We encourage residents or family to be involved in care planning so that we can fully explain the services offered and how we go about trying to meet their needs" .People told us, and records showed this was the case. For example, a relative told us how, following a review with the registered manager, his family member was now receiving assistance at mealtimes.

Care plans were kept in a locked box in people's rooms where people could see them if they wanted to. A brief summary was kept in the wardrobe so staff could find out about people's needs quickly and easily, and staff referred to them frequently during the inspection. Care plans contained information about people's individual support needs including their personal and medical history, physical and mental health needs, routines, strengths and abilities, mobility and sensory needs. People's preferences were recorded, for example, "I like to have my curtains closed when the light begins to fail". One care plan informed staff how to help a person to orientate themselves, "I can be forgetful at times and need staff to reassure me when I get confused. Staff need to be patient with me and orientate me to time, place and people. I like to have my calendar in a place that I can see it". Information about any changes to people's support needs was shared at daily staff meetings, staff handovers and in daily records.

Although people without a masonic connection could apply to move into the home, priority was always given to freemasons and their families. In the PIR the registered manager described the initial assessment process; "The assessment process seeks to identify their care and support needs', including what is important to them (for example, their values, beliefs, hobbies, preferences etc). Their family members, next of kin, or people acting on their behalf can be involved in this process, with the permission of the resident. This information is used to develop the residents care plan and as we get to know the resident better once they have moved into the Home". A relative told us the registered manager had done a thorough assessment at home with the person and their family". They were now, "settling in exceedingly well".

People could choose to participate in organised activities and were supported to organise their own activities if they wanted to. There were two activity co-ordinators, with plans to extend the activity programme to cover seven days. The activity co-ordinators spent time with people, learning about their background and interests and discussing new things they might like to try. These discussions were documented in care plans. A relative told us their family member had tried Tai Chi and was particularly enjoying the social life at Cadogan Court. An arts and crafts studio was being developed, initially to house one person's easels and painting equipment, but open to everybody. There was a computer in the lounge for people to use and a 'shop' on site which was staffed by people living at the home. People received a

monthly newsletter with photos and news about events, and details of the next month's programme. This included birds of prey, music and singing, bingo and church services. Special events were celebrated, like the Queen's birthday, when there was a special lunch with wine and entertainment. The activities co-ordinators also worked with people individually or visited them in their room if they were unable or unwilling to participate in communal activities.

Additional activities were provided by volunteers and other external agencies. A nationally acclaimed arts project "used movement, poetry, music, memories and imaginative leaps to engage, transport and enhance the lives of older people". Other such activities included a poetry group, visiting water colour artists, aromatherapy and individual trips out to the pub or the shops.
In the PIR the registered manager stated, "Friendships are encouraged and care is taken to introduce residents to a compatible group e.g. in the dining room, at activities etc. Residents are supported in maintaining links with the wider community e.g. residents are helped to attend their place of worship or to continue hobbies/activities outside of the home".

The provider had a written complaints policy and procedure. Written information about how to raise a complaint was given to people and on display in the home, and there was a 'Compliments and Complaints' box in the reception area. People told us they had confidence in the registered manager and would feel comfortable taking any concerns to them or other members of staff. Relatives told us about concerns they had raised, and how the registered manager had resolved them. Comments included; "I would raise concerns. They are very approachable" and, "The manager wants to know so they can deal with things". We saw the registered manager had worked closely with people and their families to resolve concerns. In the PIR they stated, "We aim to ensure all complaints are investigated within a 28 day period and inform residents (or those making the complaint) of our steps to address their concerns both verbally and in writing… We make every effort to discuss complaints in face to face meetings whenever possible". They told us, "We always apologise and make sure we investigate properly. If a change of practice is needed it's put into place".

Requires Improvement

Is the service well-led?

Our findings

The home had been without a registered manager for five months, and at the time of the inspection was managed by a person newly registered with the Care Quality Commission as the registered manager for the service. 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 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. 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.

People, relatives, staff and other professionals were complimentary about the newly registered manager and were positive about their ability to 'turn things around'. A relative told us, "There was a different manager when I first came. It's been a difficult transition period, but managed well. [The registered manager] is approachable, all the main managers are. They couldn't be more helpful." Staff commented, "[Registered manager] is trying their best to sort it out. It could be a lovely, lovely home and they are trying really hard", and, "[Registered manager] is bringing structure and clarity. They have reinforced that we are a good team. We all need to work as a team over the next six months. They are approachable. They listen". A health professional told us they had been working closely with the new manager to make the necessary improvements at the service. It had been "two steps forward and one back", but they had, "put lots of good things in place and were working well together".

The registered manager was supporting staff through a period of fundamental change, with the support of a mentor and the organisation's senior and regional management teams. They had arranged workshops for staff to help them understand and manage the process of change. The registered manager told us there had previously been no direction for staff, and they were now introducing clear boundaries and discipline, which had been welcomed. A weekly service improvement meeting was held to review progress. This meeting included key staff who might be struggling with the changes. Additional staff meetings were arranged as needed. The registered manager told us they were, "Developing an open and transparent culture. People need to feel safe. It's about building relationships and working with people. The priority is to get a staff group that can move forward together. They need nurturing; they've been a bit lost".

The registered manager told us, ""I want this home to be the best home, give the best care, for people to want to come and work here". In the PIR they stated, "We are personal, caring for residents and each other in a way that meets their individual needs. We are professional, drawing on best practice to work together and provide expert care. We are supportive, enabling our residents to live the best lives possible – and fostering a sense of community within the RMBI and our Homes. We are learning, continually seeking out ways to improve what we do, using mistakes as development opportunities and embracing innovation and creativity in our approach to care. We are respectful and proud of our heritage, our residents and each other. Above all, we are kind; dealing with everyone we meet both compassionately and warmly. We listen to our residents, their families and those acting on their behalf".

At the time of the inspection the 'Dementia House', was near completion. This was a separate wing of the home catering for people living with dementia who had more complex support needs. The registered manager spoke passionately about this development of the service. They were working to recruit the 'right staff team', which would be stable and built over time. Staff were being trained in a person centred model of dementia care which improves quality of life and helps people feel valued. The head of catering told us they were learning how to effectively meet the nutritional needs of people with dementia, "We are arranging to visit other homes to see and watch and learn." The registered manager told us activities would be 'things you would do in your daily life', with a focus on building confidence and maintaining independence, for example, preparing meals in a specially adapted kitchen or working outside in a workshop. Funds had been raised by 'the friends of Cadogan', to equip the new dementia house, with specialist furniture and equipment that would enhance the lives of the people living there.

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The registered manager was developing a line management structure to provide clear lines of responsibility and accountability. Plans were in place for all staff to receive individual supervision and appraisals, and there were regular staff and management meetings. In the PIR the registered manager stated, "We are developing improved communication and support services for staff at Cadogan Court. We currently have regular meetings with staff to ensure everyone knows what is expected of them, and what we can do as a Home Management Team to help them excel". They told us they were, "happy to go to work with staff and lead by example". The registered manager had an 'open door policy', and was very visible 'on the floor'. They had lunch at a different table in the dining room every day, walked around the home to speak to people and observe support being provided and attended staff handovers. They also ensured they met regularly with night staff. One person said, "It's a first class place. Extremely well run" and a relative told us how kind the registered manager had been to their family member.

The provider and registered manager had developed a range of quality monitoring systems which were being used to monitor the care and environment at the home and improve the service. This included monitoring call bell response times and looking at areas such as care plans, staffing, policies, medication, accidents and incidents, complaints, equipment and infection control. In addition regular spot checks were completed by senior staff in the organisation. People's views were sought, residents and relatives meetings were held regularly, and improvements made in response to feedback. For example, there were plans to make part of the dining room into a bar area, in response to requests from people. An independent annual satisfaction surveys for people, families and stakeholders helped to identify strengths and areas for improvement.

As far as we are aware, the provider met their statutory requirements to inform the relevant authorities of notifiable incidents. They promoted an ethos of honesty, learned from any mistakes and admitted when things went wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The registered manager was proactive in building positive working relationships with local GPs, pharmacists, health care specialists, volunteers and community for the benefit of the people living at Cadogan Court. They participated in various forums for exchanging information and ideas and fostering best practice. In the PIR they stated, "The RMBI as a whole is involved in a number of best practice initiatives…We have internal staff recognition programs, including long service awards and the Oskars program - where staff can be nominated to recognise their contributions to the Home. We also are a member of the National Care Forum. We regularly contribute to discussion papers and similar requests on our experiences and views on sector wide reforms. Where possible, we adapt learning from the forum into our organisation and Homes".

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Where a person lacked mental capacity to consent to care and treatment, the service did not always follow a best interests process in accordance with the Mental Capacity Act 2005.(13)(4)(d)