The Royal Masonic Benevolent Institution

Devonshire Court

Inspection report

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Date of inspection visit:
10 August 2016
11 August 2016

Date of publication:
11 November 2016

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

We inspected Devonshire court on 10 and 11 August 2016. This was an unannounced inspection. This meant that the staff and provider did not know that we would be visiting.

At our last inspection of the service on 2, 3 and 4 March 2016 the provider was failing to meet five regulations. These related to governance, safe care and treatment, statutory notifications, need for consent and safeguarding service users from abuse and improper treatment. We issued the provider with a warning notice in relation to governance and safe care and treatment at the service and told them that they needed to improve. We also issued them with a requirement notice relating to statutory notifications, need for consent and safeguarding service users.

At this inspection we found that the provider had failed to address all of the concerns and we identified further concerns about the governance of the service.

Devonshire Court provides nursing and residential care for older Freemasons and their dependants. The home is registered to accommodate up to 69 older people and there were 54 people using the service on the day of our inspection visits.

At the time of our inspection the service did not have a registered manager. The manager in post was in the process of applying to become the registered manager. They were successful in their application in September 2016. 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 2008 and associated Regulations about how the service is run.

We identified that the provider was in breach of four of the Regulations of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 and with one of the Regulations of the Care Quality Commissions (Registration) Regulations 2009. 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.

Safeguarding concerns had not been identified and reported appropriately and consistently. People were not supported in a way that ensured that they did not pose a risk to themselves or others.

Where risks had been identified, the actions that should be taken to reduce the likelihood of the risks causing harm were not clear. Where risk assessments were in place there was not always reference to the Mental Capacity Act 2005 (MCA) to promote people's rights and where people were unable to give their consent, best interest decisions were not always recorded as having taken place.

People could not be sure that they would receive their medicines as prescribed by their doctor. People's

medicines were not always administered correctly and the provider had not taken appropriate action to prevent further errors. Medicines records were not always accurate and systems to check medicines were not robust. Where people required medication to be administered as required, staff had not been given clear guidance about how to undertake this.

The provider had a recruitment policy in place which was followed. We found that all the required pre-employment checks were carried out before staff commenced work at the service. The provider had taken action to ensure people were supported by staff who were familiar to them. Staff had received training to meet the needs of the people who used the service

People's independence was promoted and staff treated people with dignity and respect. We observed staff interacting in a caring manner with people. Staff knew people well and understood what was important to them. Most people were supported to follow their interests and engage in activities.

The provider had considered their responsibility to meet the requirements of the MCA and Deprivation of Liberty Safeguards (DoLS). Where people did not have the capacity to make decisions best interest decisions had been made on behalf of them in line with the requirements of the MCA. Records relating to best interest decisions were not in depth and it was not always clear who had been consulted.

People enjoyed the meals provided and where they had dietary requirements, these were met.
Systems were in place to monitor the health and wellbeing of people who used the service. However these were not always effective. People's health needs were not always met and when outside health professionals had been contacted for support, people's care records did not make clear what guidance had been given.

Care plans, as identified by provider's own audits, did not include sufficient detail about how to support people. People were not always involved in making decisions about their care, treatment and support.

Where people had requested maintenance work to be carried out in their bedrooms this had not been actioned and they had not received feedback about when action would be taken.

The provider did not have robust monitoring of significant events, such as behaviour that challenged, that happened within the home. The providers own audits had not always been effective in identifying faults and putting systems in place to rectify them. The provider had not taken action to address all of the concerns identified at our last inspection.

People using the service and relatives were not clear on who the manager was. People had been made aware that a new manager was in place and had been at the service since June 2016. Staff felt supported by the new manager. Changes in the management team since our last inspection meant that there had been no continuity of management to follow through and implement the action plan to address concerns we raised.

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 timeframe. 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Safeguarding concerns had not been identified, managed and reported appropriately and consistently.

People's medicines were not always administered correctly and the provider had not taken appropriate action to prevent further errors.

Where risks had been identified the actions that should be taken to reduce the likelihood of the risks causing harm were not clear.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's nutritional and hydration needs were assessed and met. People's health care needs were not always met and their records regarding any health professional contact were not robust

Where people did not have the capacity to make decisions, best interest decisions had been made on behalf of them in line with the requirements of the Mental Capacity Act 2005. People's care records relating to best interest decisions were not in depth and it was not always clear who had been consulted.

Staff had received training and support to meet the needs of the people who used the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff treated people with kindness and compassion.

People's independence was promoted and people were encouraged to make choices.

People were not always involved in making decisions about their

care, treatment and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People's care plans, as identified by provider's own audits, did not include sufficient detail about how to support them.

Most people were supported to follow their interests and engage in activities.

People knew how to make a complaint or raise a concern and were confident they would be listened to. Not everyone felt that they were asked for their opinions about the service that they received.

Is the service well-led?

Inadequate

The service was not well led.

The provider's audits had not always identified areas that required improvement. Not all of the concerns raised at our last inspection had been addressed.

The provider had not always made the appropriate notifications about incidents at the home to the Care Quality Commission.

People using the service and relatives were not clear on who the manager was. Staff felt supported by the new manager. There had been a lack of continuity in the management team.

Devonshire 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.

We undertook an unannounced inspection of Devonshire Court on 10 and 11 August 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 2, 3 and 4 March 2016 inspection had been made. This is because the service was not meeting all of the legal requirements.

The inspection team consisted of three inspectors, a specialist nurse advisor and a specialist pharmacy advisor as well as 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. We spoke with eleven people and five relatives of people who used the service.

During our inspection visit we spoke with seven staff members employed by the service. This included the cook, a domestic member of staff, an activities coordinator, a catering assistant and three care workers. We also spoke with the newly appointed manager and the regional operations manager who was working at the service to oversee its daily running. We also spoke with one member of staff who was working at the service who had been supplied by a care agency. We looked at the care plans and care records of 12 people who used the service at the time of our inspection. We looked at four staff recruitment files to see how the provider recruited and appointed staff. We also looked at records associated with the provider's monitoring of the quality of the service and staff training.

We observed care and support provided in the communal areas of the service. This was so that we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with. We also 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.

Before the inspection we reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted health and social care professionals who have contact with the service to gain their views of how the service was run and the quality of the care and support provided by the service.

Inadequate

Is the service safe?

Our findings

During our 2, 3 and 4 March 2016 inspection we found that the provider had failed to safeguard people from the risk of abuse. We checked to see if they were now meeting this regulation and found that they were not.

We spoke with staff who were aware of the provider's safeguarding policy, their responsibilities and had received training. There were clear on what actions they should take and how to identify the different types of abuse. However, we saw that the manager and staff had not identified and reported concerns to the local authority safeguarding team or other relevant bodies as appropriate and had not taken measures to protect people from the risk of abuse.

A person who was a known risk to other people had not always been supported in line with the guidelines as set out by the local authority's safeguarding team. As a result we saw that the person had been able to have contact with other residents in a manner that meant they were at risk of harm. We reviewed records which showed that they were times when the person was not being observed. The provider was not able to demonstrate that they had consistently followed the guidelines. On another occasion we saw that an altercation had taken place between two people who use the service. The incident report indicated that there had been physical contact between them and a person had sustained a bruise as a result. We raised this with the manager who told us that they had discussed the incident with the staff member who had completed the incident report. They told us that no bruise was sustained and that this had been recorded in error. The manager had been unaware of any of these incidents as they had occurred prior to them being employed at Devonshire court. The incidents had not been reported, as per the provider's policy, to the local safeguarding authority for investigation. Since our inspection the manager had conducted an enquiry into the incidents.

One person whose behaviour caused other people anxiety was not supported with their behaviours in order to prevent anxiety. Staff were required to be aware of the person's whereabouts at least every 15 minutes as had been documented in their care plan. We found that on seven occasions over three months the person had behaved in a manner that put them at risk of harm and had the potential to impact on other people's rights and privacy. Staff had been making the observations however these had not been sufficient to prevent the behaviour impacting on others. The systems and processes in place to protect people at the service form risk of harm had not been effective.

These matters are a breach of Regulation 13: Safeguarding service users from abuse and improper treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014.

During our last inspection we found that the provider had failed to provide safe care and treatment to people. We were aware that the local authority safeguarding team had investigated and substantiated a number of concerns relating to the administration of medicines to people at Devonshire Court. The manager had informed us of further occasions when people had not received their medicines as prescribed by their doctor. We checked to see if they were now meeting this regulation and found that they were not.

We found that people could not be assured that they would receive their medicines as prescribed by their doctor. Staff used an Electronic Medication Management System (EMMS) to tell them which medicines to give people and to record when they had been given. Staff told us that the medication system was very demanding. There were multiple medicine administration times throughout the day. The nurse on duty told us that they had little time for anything but managing people's medicines.

We were made aware of medicine errors that had taken place since our last inspection. There had been times when people had received too much or not enough of their prescribed medicines. For example in July a person received medication to help manage the symptoms of their Parkinson's disease twice. This may have increased the risks of having side effects from the medicine and the effectiveness of controlling their Parkinson's disease. .A similar error occurred later that month where a person received medication for their Parkinson's disease almost three hours too early. Which may have affected the effectiveness of controlling their symptoms. The provider had not always carried out a full investigation as to why the error occurred or took action to prevent further errors. We were told that the cause of many of the errors was an issue with the computerised system that staff used to guide them. During our last inspection we had identified the issue with the system and had been told that the provider would make changes to the way the system operated. The provider had not taken appropriate actions to address the problems with the computerised system and therefore to prevent further medicine errors occurring.

During our last inspection we found that the amount of medicines that were kept at the home was not accurately recorded. During this inspection we saw that the stock records did not match the actual amount of medicines within the home. This made the system unsafe because the provider could not assure themselves that there was enough medicines to meet people's needs or that medicines were not being misused.

At our last inspection we found that there were no PRN and variable dose protocols in place. PRN medicine is prescribed where needed by people's doctors on an as required basis. We found that the provider had not implemented these at this inspection visit. We raised our concerns with the provider as where a person was prescribed a medicine to help them remain calm; there was no guidance in place for staff to follow about when and how to give the person their medicine. We found that there were eight occasions when this person had received more than the recommended dose of the medicines at one time and that staff were not clear on how and when to give the medicines. This person was at risk of falling and the medicine they were given would have made them more likely to fall if taken in a larger dose.

During our last inspection we found that people were not always receiving the cream that was prescribed to keep their skin healthy. At this inspection we found this to still be the case. We were aware that the local authority's safeguarding team had identified that people were not receiving their creams as prescribed in July 2016. The provider had failed to take action to ensure that people's skin was protected.

The provider had failed to ensure the safe management of medicines at Devonshire court. These matters are a continued breach of Regulation 12: Safe care and treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014

People told us that they felt safe. One person said, "Oh, it's fine and no-one worries me." Another told us, "I feel safe with the staff." However, people told us that there were not always enough staff to meet their needs. Comments included, "They could do with a few more people", "On some occasions they're a bit short, like taking us for meals. It can be a long wait" and, "It can be an issue at times getting someone." Most people told us that when they used their call bells to request assistance staff came promptly. We saw that staff appeared to be busy but able to respond to call bells. The manager monitored response times to

identify instances of unduly delayed responses, for example, if a response took more than 10 minutes. We reviewed response times over a two day period and found that most people had received support within five minutes of using their call bells. On the day of our inspection we found that there were sufficient staff to meet people's needs.

At our last inspection we identified that risk assessments had not been updated following an incident and that they were not robust. At this inspection visit we found that when an incident, such as a fall, had taken place this was recorded but the actions that should be taken to reduce the likelihood of reoccurrence were not clear. For example we saw an accident record where a person had fallen. The record demonstrates what measures had been in place prior to the fall but not if further measures were required as a result of the most recent fall. This meant that people were at risk of further harm.

The service had an up to date contingency plan for managing emergencies such as fire, flood, and loss of utilities. Fire alarms were tested weekly and audits of the home environment were carried out regularly. These included weekly and monthly checks of water temperatures and legionella testing. During our inspection visit the fire alarm was tested. As part of the testing process fire doors closed automatically. We observed that this caused some residents distress as they were coming and going from the dining room at that time. We had received a concern from a visiting professional in July 2016. They were concerned that staff were unclear on how to react to the alarm and residents seemed to be confused and upset by the fire alarm sounding and doors closing when they had visited in July. We reviewed the fire drill record for this date; the report stated that there were no concerns. We asked staff if they were clear on what action to take in case of a fire. They assured us that they did know and had received suitable training.

The provider had robust recruitment procedures. These ensured as far as possible that only people suited to work at the service were employed. All necessary pre-employment checks were carried out. These included the Disclosures and Barring Service (DBS) checks. These are checks that help to keep those people who are known to pose a risk to people using Care Quality Commission (CQC) registered services out of the workforce.

Requires Improvement

Is the service effective?

Our findings

At our 2, 3 and 4 March 2016 inspection we found that medical attention had not been sought in a timely manner when a person's condition had deteriorated. These matters were a breach of Regulation 12: Safe care and treatment. Health and Social Care Act 2008 (regulated activities) Regulations 2014. At this inspection we found other examples where people had become increasingly unwell and staff did not identify that they required medical attention. For example, a person who was suffering from increased repeated coughing and choking was not referred to a health professional for specialist advice. The records that were kept around people's contact with health professionals were not robust and did not make clear what the reason was for the contact. For example, we saw that one person had fallen and broken their clavicle. They saw a GP on the same day but the records of the visit made no mention of the fall or broken bone, only that the person had become increasingly unwell. This was a concern because it was not clear if the person's GP had been made aware of the fall. There was a risk that the person did not receive medical attention appropriate to their condition.

People told us that they had access to health professionals when they needed to. One person said, "I'm under an optician at the moment here. The chiropodist is very good." Another person told us, "They take me out to the dentist. I'm waiting for the eye people to come in. We have a lady chiropodist who's very nice." Relatives confirmed this. One relative told us, "The district nurse is always in and out to do her leg, so she's well looked after. One of the staff is qualified to do her toes." Another relative told us, "They're good at getting the doctor in when needed. She has the optician and chiropodist coming in – the optician even engraves their name on the specs arm. So they can't get lost." People's health records confirmed this.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) as it had not been during our last inspection. These matters are a continued breach of Regulation 11: Need for consent: 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Most staff had received training in relation to the MCA and understood how if affected their role and the people they were supporting. One staff member told us, "The MCA protects everyone, staff and residents. We have to presume people have capacity, but if they don't decisions can be made in their best interests". Mental capacity assessments had been completed and the appropriate records were in place. We saw that there was reference to people's ability to make decisions in their care plans.

Where people did not have the capacity to make decisions best interest decisions had been made on their behalf in line with the requirements of the MCA. For example, we saw that a best interest decision had been taken to not use bed rails for a person, who lacked mental capacity, due to the risk of greater injury if they

attempted to climb over the rails. Records relating to best interest decisions were not always in depth and it was not always clear who had been consulted. Where risk assessments were in place there was not always reference to the MCA and best interest decisions having been taken. The manager informed us that they planned to review how best interest decisions were taken and recorded.

A lasting power of attorney can be appointed in advance to make decisions on behalf of a person if they begin to lack capacity in the future. We found that records relating to who could make decisions on behalf of people were not available at the home and that decisions had been taken by people who may not have had the legal right to do so. This meant that for one person part of their care and treatment regime had been stopped without due consultation. This decision had been a contributing factor to the person's placement at Devonshire Court being terminated.

People told us that staff asked for their consent before delivering care. One person said, "They're usually good at asking." Another person told us, "They'll ask me before doing something." We saw that people's consent had been sought. For example, one person had been asked if they would like to have bed rails fitted to their bed.

People told us that they were supported by staff who had the knowledge and skills to meet their needs. Comments included, "Some are very well informed but some newcomers are still learning.", "They seem very much qualified and teaching on the job. The night agency nurses are OK too. If you get a newbie on, they shadow and staff usually tell them about me" and, "They appear to be good enough."

Staff were supported through monthly supervision meetings. A care worker told us, "The meetings are helpful. I get feedback about my performance. The meetings give me an opportunity to reflect". The manager monitored a schedule of staff supervision meetings. At the time of our inspection 81% of staff had their supervision meetings at the scheduled times. Staff were also supported through training. They told us they found the training helpful because it helped them carry out their roles and responsibilities. One told us, "The training is helpful. It's covered everything I need. We have training about medical conditions people live with. We can ask for training we think we need". The service had a training plan that was monitored by the manager. This showed what percentage of staff had completed particular training. We saw that most staff had completed 80% of the training that was planned and were scheduled to complete the remainder. We saw that staff had received training and competency checks before they were allowed to administer medicines. Competencies checks could not be relied upon to ensure that staff had sufficient skill to administer medication safely. This was because staff who had been deemed competent to administer medicines had made errors soon after their competency assessments. The manager told us that they planned to introduce a new system to check staff competency that would be more effective.

The service had been reliant on the use of agency staff at our last inspection including trained nurses. The manager told us that although they were still using agency staff the number had decreased as their own recruitment processes had been effective. On the two days of our inspection the nurse on duty was employed through an agency. The agency nurse we spoke with confirmed that they had been provided with training and support when first being assigned to the service. The nurse told us that they had been booked for regular shifts in order to promote consistency of care to people. A staff member confirmed that new staff had been recruited. They said, "New staff are being inducted. They do a shift on each floor. They shadow a senior or experienced member of staff."

At our last inspection we identified concerns that people who were at risk of dehydration and malnutrition were not being appropriately monitored. At this inspection we found that action had been taken to address this. One person told us, "I like the cranberry juice. We get plenty to drink."

Another person said, "The eternal cry here is 'You're not drinking enough'!" Relatives agreed that people were encouraged to drink. One relative told us, "She needs a lot of encouragement and they push (encourage) her well." Another relative said, "She needs reminding to drink and has plenty in her room." We observed people being offered drinks throughout our visit. One person was noted in their care records to have been monitored for food intake due to weight loss. However, after gaining weight the food recording had now ceased but continued to be supported by a monthly Malnutrition Universal Screening Tool. Where people were considered to be at risk of dehydration, there were care records in place recording their fluid intake. People's daily fluid intake was totalled and monitored by the night nurse. This meant that people who were at risk of dehydration were being monitored and systems were in place to ensure that actions were taken if people did not drink enough fluids.

People had a choice of breakfasts, lunchtime meals and tea-time meals. A person using the service told us, "The meals are good" and another said, "We have a good choice of meals" A relative told us, "The breakfasts are excellent, to the standard of a top hotel". The choice of meals was varied and people were served alternative meals if they did not want something from the menus. Meals were prepared on site. The cook and kitchen staff who assisted in the preparation of meals knew about people's nutritional and dietary requirements. They knew which people required their meals to be served in soft or pureed form. They also knew which people required a specialist diet and who therefore required suitable foods. We saw staff encourage people to eat when they were at risk of malnutrition and dehydration. When people refused food staff prepared them alternatives and offered them in ways that people seemed to be more comfortable with. For example, we saw that a staff member offered someone a cup of tea, which they accepted and then brought them some biscuits to go with it which they then ate, having previously refused other options offered.

Requires Improvement

Is the service caring?

Our findings

We received mixed views about how people were involved in their own care planning and making decisions. Relatives felt involved in people's care but most people themselves told us they had not been involved in making choices about their care and support. Comments included, "My family do that for me.", "I've never been asked about it before.", "They don't talk to me about it." and, "They talk about my medication with me. My husband spent a long time today talking to them about my care."
People did not routinely review their own care records and information that the home kept about them. People told us that they were involved in daily choices. For example one person said, "They put me to bed when I'm ready." Another person told us, "I look through my clothes and decide what to wear." A third person said, "I decide lots of things." However one person told us, "I get a weekly shower but they give us a time, we don't get a choice. But I decide on my bedtimes and what to wear." And another person said, "If I want a bath, I have to ask and they'll diary it. I have one a week." During lunch time we observed that people were not always offered choices. For example, we saw that cream was put on some people's pudding without them being asked. The manager told us that they intended to improve the opportunities for people to become more involved in planning and making decisions about their care.

We saw that staff were kind and caring. Staff spoke politely with people and referred to them by their name. They were attentive to people's needs. When a person who told a member of staff "I'm walking along but I don't know what to do", a staff member replied, "Come and have a seat and I think I know what you'd like". A few moments later the staff member brought the person a dog to play with. The person's response was clearly one of delight. In another example we observed a staff member in a dining room with two people who were living with advanced dementia. The staff member spoke in a low calm voice, stroking one person's hand and talking about the doll they were holding. The second person sat listening and smiling, with the carer keeping eye contact with them and smiling too. However, during our visit the fire alarm test was carried out three times in the middle of lunch. This caused disturbance while people were talking or eating. We observed that some people became anxious and upset about this. Staff offered minimal reassurances. This meant that people were not treated with kindness at a time when they were in distress.

Staff respected people's privacy. One person said, "They're always respectful and close my door and curtains." During our inspection we observed staff knocking before they entered people's bedrooms. One staff member said, "It's their home first and foremost." We saw several people spending time in a variety of quiet areas. Staff did not disturb them but they made discreet observations to make sure people were safe and comfortable. People were able to entertain visitors in their rooms or in quiet areas.

People were able to move around the home unrestricted depending on their support. One person told us, "I can't go out the back in case I wander off. But I can go round the home where I want." Another person said, "I've never been stopped doing things by anyone – and I can go and get fresh air on the patio."

People told us that staff knew them well. Comments included, "They certainly know us well.", "I suppose they do know me, they know my likes.", "They know my little ways." We observed staff talking to people about things that they enjoyed and were interested in. On one occasion we observed a domestic staff

member starting a conversation with a person who was becoming unsettled. They talked about the person's pervious occupation and places they had been. This conversation helped the person to relax and reengage in the activity that they had been involved in.

People told us that staff did not spend quality time with them aside from performing care related tasks. Comments included, "Not really. They're busy doing jobs.", "They've no time for that, and they chat across me in their medical lingo at times.", "Oh no, they don't spend any time with us, they have their own jobs to do." And, "No, they're too busy to stay with us." We did observe that in the smaller units within the home staff spent time interacting with people and engaging in recreational activities. One staff member told us that they enjoyed, "Taking time to talk with them and sit."

People were supported to maintain their independence. One person told us, "They let me do as much as I can. They know what I can do and capable of." Another person said, "They do indeed encourage me to do what I can." A third person said, "The staff encourage me to be independent. They know what I can do for myself and they let me do those things, for example, fold my clothes and put them away the way I like." We saw that people had access to kitchenettes where they could make themselves drinks if they had the skills. People's care plans provided limited information about what tasks people could do for themselves.

People told us that staff were caring and treated them with kindness. Comments included, "They're all very nice." "They're very kind and generous.", "They're all so kind." and, "They're all friendly and helpful."

People were supported to maintain contact with others who were important to them and maintain social links. One person told us, "We've got nice groups of people we can mix with." Another person said, "I have several people here I call friends". Relatives told us that they were able to visit at any time unrestricted. One relative said, "I can come anytime, at all hours." Another relative told us, "We're kept well informed."

Requires Improvement

Is the service responsive?

Our findings

People's care files were computer based. This meant that staff needed access to a computer to identify the care required and for updating when people's needs changed. Each individual person's file also contained 'Summary Care Plans', which provided an overview to support staffs understanding of people's needs. We saw that the summary care plans were available in each person's bedrooms but that staff were not aware that they were there and as a result did not refer to them. This meant that staff were reliant on checking the computer based records for guidance. This was not always possible as other staff members needed to use the computers.

At our last inspection we identified that it was not clear within the people's care records how individual's risk assessments were linked to their care needs. At this inspection we found that where staff were required to take action to reduce the likelihood of a risk causing people harm they were not always prompted to refer to the risk assessment. This meant that there was a risk that staff were not clear on what action it was that they should take. These matters are a continued breach of Regulation 17: Good governance. Health and Social Care Act 2008 (regulated activities) Regulations.

People's care plans, as identified by provider's own audits, did not include sufficient detail about how to support people. For example, one person's care plan stated that their triggers for agitation are a fear of going to hospital. However, their care plan stated 'Try and calm [person's name].' There were no detailed strategies in place. We saw that another person had been receiving one to one support as a result of a recommendation from a health professional. When this support stopped staff were not offered additional guidance as to how to help this person manage the symptoms of their condition which were distressing for them. This meant that people were at risk of not receiving consistent support that was tailored to their specific needs.

People told us that their care needs were met. One person said, "I'm very well looked after". Another person told us, "I get the support I need". Where people required staff intervention to help them remain well and have their care needs met we found that these were mostly followed. For example, where a person required regularly repositioning to help their skin remain healthy and prevent pressure sores this had been completed. Staff confirmed this. We reviewed records that demonstrated that most people had been repositioned in line with their care plan guidance.

Staff were kept up to date through handover of people's needs changed. A handover is a meeting between staff who have been working and new staff who are coming in to work. We observed handovers and information about people was detailed and changes to people's conditions were shared. We saw that there was a hand over sheet where the shift leader or nurse documented an over view of how each person had been throughout the day. We saw that this document had prepopulated information about each person which was there to act as a prompt to staff to ensure that they supported each person's individual needs. We saw that the prepopulated information was not always up to date or robust. For example we saw that one person who was due to be under regular observation no reference was made to this. This meant that there was a risk that staff did not always have the most up to date information about people's care

requirements.

People using the service were able to request maintenance work they felt was required in their rooms, for example new light bulbs or the fitting of televisions. They did this by making an entry on a maintenance report sheet. We noted that entries that had been up to seven days before our visit had not been actioned. People had reported things such as broken electrical sockets, broken extractor fans, door handles and blinds. One person had made four requests for a television to be mounted to a wall. This meant that the provider had not acted upon people's feedback and requests.

The service employed two full time activity co-ordinators. A dedicated activity room was located near the dining room for arts, crafts and group events. There was a large communal lounge where activities and social events took place. A noticeboard by the dining room had a display of all forthcoming events to inform people using the service. Recent events included cider tasting, word games, drinks on the terrace, book reading and a gentleman's morning in the conservatory.
We saw that monthly booklets 'Devonshire cream' were produced to inform people of events and activities as well as quiz pages and topics to read. The activity –co-ordinators organised group events as well as visiting people in the smaller units or their bedrooms to provide interaction.

Not all people were supported to follow their interests. Most people felt that they were involved in activities and had enough to do. A person told us, "There's usually enough to do. I like the quiz and we like to support any events. They quite often use the minibus, I've just been to Rutland Water. The communion service here is very good." Another person said, "It's quite good, I've taken part in some things if I can hear. I liked the indoor bowls. I'll read if I get bored. I go on the outings if I can." A relative told us, "The activities are great. There is none of this sitting around in a circle doing nothing I've seen at other homes". However some people told us that they were not able to get involved in the activities offered. One person said, "I wish I could do some hand movement therapy to keep my hands active. No-one comes up to me, it's all downstairs activity." Another person told us, "I sometimes wish there was more on, I like the poetry group or join in an outing. They don't often come and look for me to join in though." We observed that one person was hard of hearing so declined the morning quiz and afternoon music activity as they would not be able to hear enough to join in. We observed this person sitting alone in the conservatory in the morning and alone in the foyer in the afternoon. This showed that not everyone was supported to follow their interests.

People knew how to make a complaint or raise a concern should they have needed to and were confident they would be listened to. One relative told us, "I've had no cause to complain but I know who to complain to if I had to." Another relative said, "If I'm concerned I have no problems accessing people." We saw that the complaints procedure was clearly displayed within the home. No-one we spoke with had felt the need to raise a complaint. The manager confirmed that there had not been a complaint made since our last inspection.

Not everyone felt that they were asked for their opinion about the service that they received. One person said, "I've not done any feedback." Another person told us, "I've never been asked or do a form." However, relatives told us that they had been asked to complete surveys in the past.
People told us that they had heard of or attended residents' meetings. One person said, "I think there's one due this week. They usually respond to us after." Another person told us, "I've sat in on one but not sure about what's done after." We saw from resident meeting minutes that people had discussed things such as the range of activities and meals and things they would like adding to the menu. They discussed aspects of the service such as the laundry service. They also received information about changes such as changes to staff uniforms so that they knew which staff wore which colour uniform. These meetings happened approximately every three months. Relatives told us that they felt listened to. One said, "Oh crikey, yes. They

certainly take notice of us." There appeared to be no opportunity for residents on bed rest to be included in agenda planning or giving opinions. One person told us, "I can't get there as I'm stuck in bed. But why can't I submit my ideas to them?" This meant that the provider had not considered how they could seek the feedback from everyone living at the home.

Inadequate

Is the service well-led?

Our findings

Providers are required to ensure that CQC is informed of significant events that happen in the home. At our 2, 3 and 4 March 2016 inspection we found that the provider had failed to notify us of significant events. At this inspection we identified a further four occasions when we had not been made aware of safeguarding events where people had alleged or were subject to actual abuse. Therefore the provider had continued to not notify us of incidents as required.

This constituted a continued breach of Regulation 18 of the Care Quality Commissions (Registration) Regulations 2009

During our last inspection we found that the way that the service managed people's finances was not robust enough to keep people's money safe. Since our last inspection the provider had changed the system to ensure that people are safeguarded from financial abuse. However the provider had not taken into consideration the need to complete an audit of people's accounts held at the home prior to our last inspection. This meant that people could not be sure that their money had been managed appropriately in the past and action to seek reimbursement be taken if required. This demonstrated a lack of transparency within the service. Since our inspection the provider had commissioned a full audit of people's accounts.

At our last inspection we found that robust monitoring of significant events that happened within the home was not taking place. This included the absence of monitoring falls and incidents of behaviour that may cause harm. Systems were not in place to ensure that when these events occurred the provider took action to prevent further reoccurrence and learn wider lessons for the care of other people using the service. At this inspection we found that there remained a lack of robust systems in place. For example, we saw that where people had experienced falls it was not clear what actions had been taken to prevent further occurrences. Where staff had recorded on people's behaviour charts instances of challenging behaviours these were not routinely reviewed. We saw that further incidents had occurred where people had been at risk of harm as no action had been taken in relation to the previous occasions. The manager had not maintained an oversite of these incidents and as a result action had not been taken. The provider had failed to assess, monitor and mitigate the risks to people.

During our previous inspection we saw that the provider did not assess and monitor the quality of the service provided to people. As part of this inspection we saw that systems in place to check and monitor medicine administration and storage within the home were not robust and had not picked up our areas of concern. For example, where people required cream to help keep their skin healthy this was not recorded consistently. Documentation that indicated that people were not receiving their creams as prescribed been highlighted as a concern at our last inspection. The provider had failed to act on the feedback they had received and this continued to put people at risk.

After our last inspection the provider told us that they would take action to address how they managed people's medicines and creams. We had been made aware of a number of medicine errors that had occurred since our last inspection. The cause of this was attributed to the electronic administration system.

One staff member told us, "The internet is not very good. That is why we have sync errors." We had identified issues with the electronic administration system at our last inspection in March 2016. This issue had not been addressed and had resulted in further errors. The most recent having occurred on 5 August 2016 when a person received their pain medicines twice. The provider had failed to investigate, take accountability and put things right when failings had been identified this continued to put people at the service at risk.

The manager was clear of their responsibility to ensure the smooth running of the service. We saw that they conducted regular 'walk around' checks to ensure that systems were in place and were working appropriately. Staff confirmed this. We found that the manager had not identified concerns that we found during their checks. For example when people's observation charts had not been completed. We also saw that they conducted 'spot checks' at night. These checks had been implemented as a result of a concern raised by a whistle blower. The checks had taken place on two occasions however further checks had not been planned as part of an ongoing program of quality monitoring.

As part of our last inspection we issued the provider with actions that they were required to take in order to improve. We saw that some of these actions had been taken but not all. These matters are a continued breach of Regulation 17: Good governance. Health and Social Care Act 2008 (regulated activities) Regulations.

The service did not have a registered manager. The manager at the time of our inspection had been in post since June 2016. Some people we spoke with were not sure who the manager was. One person said, "I'm not sure who it is now. I'd just talk to someone in the office if they'll listen." We observed the manager dine with people in the main dining room and speak with people after the meal. One person said, "She circulates around sometimes." People's relatives gave similar feedback. One said, "I see the manager around and they say hello." Another relative said, "I've seen her once, she seems very nice." The provider told us that the manager was still within her induction period at the time of the inspection so was in the process of meeting and building relationships with the residents and their relatives. The provider had restructured the senior staffing who had over sight of the service and supported the manager with the running of Devonshire court and quality assurance. These staff were new to post at the time of our inspection. They had not been aware of some of the previous concerns that had been raised by outside professionals who had responsibility for funding and safeguarding people in the home. For example information had not been passed to the manager regarding protection plans for people. This meant that there was a lack of communication at a senior level and staff were not guided by effective management support.

Staff told us that they had confidence in the new manager and that they were approachable. One staff member said, "The new manager, she is bringing hope. Everything is in progress." They also told us, "[Manager] said if something is not working we should tell her. She wants to know. She asks staff for ideas and listens." The manager had implemented supervision sessions with staff and meetings to ensure that information was communicated to them and that they were kept updated on important matters about the service.

Changes in the management team since our last inspection meant that there had been no continuity of management to follow through and implement the action plan to address concerns we raised. This meant that parts of the action plan had not been progressed because each time a new manager started they had to appraise and evaluate what the challenges facing the service were and `re-launch' the action plan. At board level, the provider was aware of the challenges but inconsistency of management at the service had stalled progress. The new management team were clear of their roles and responsibilities.

Staff were clear of their role and what was expected of them. One staff member told us, "We are trying to work to the recommendations and do what we can to improve. We are trying to focus on that." Another staff member told us, "Our job is to keep people safe." Where staff practice had been of concern the measures that the provider took to address them had not always been effective in addressing them. We did see that disciplinary action had been taken against one member of staff as a result of concerns that we raised at our last inspection. However where medication errors had occurred the actions that the provider took to prevent further errors and retrain staff had not been effective.