The Royal Masonic Benevolent Institution Care Company

Shannon 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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Shannon Court provides accommodation and personal care for up to 53 older people, some of whom are living with dementia. There were 49 people living at the service at the time of our inspection. Everyone living at Shannon Court had a previous connection with the Masonic community.

The inspection took place on 14 June 2016 and was unannounced.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was not available on the day of the inspection. We were supported by the deputy manager and members of the senior leadership team.

Sufficient staffing levels to meet people's needs were not provided throughout the service. In some areas we found that staffing levels were adequate and people received their support in a responsive and timely manner. In other areas of the service sufficient staff were not available to ensure that people received the support they required. There was a high level of agency staff used which people told impacted on the care they received.

Staff did not always identify and act promptly to safeguarding concerns. When concerns were reported to the registered manager appropriate action was taken to minimise the impact on people. Risks to people's safety were not always identified and actions were not always taken promptly to mitigate risks.

The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005and Depravation of Liberties Safeguards. People's capacity to make decisions had not been assessed and there was no evidence that meetings had been held to ensure that decisions taken about people who lacked capacity were made in their best interests.

Whilst each person had an individualised plan of care, the information recorded was not always reflective of people's current needs. Care plans were not always completed and reviewed in a timely manner which meant staff did not always have access to the most up to date information relating to people's care needs. Records relating to people's care were difficult for staff to access due to technical difficulties with the electronic recording system.

There was a system in place to deal with people's comments and complaints however we found that the registered manager had not investigated, recorded and dealt with complaints a timely manner.

Regular audits were completed to monitor the quality of the service provided. However, these were not always effective in identifying areas which required improvement. The registered manager had responsibility

for the managements of two services which both staff and people felt had an effect on the management oversight of Shannon Court.

Medicines were managed well and risk assessments were in place to mitigate the risk of mistakes being made. People were supported to maintain good health and had regular access to a range of healthcare professionals.

The provider's recruitment procedures were robust, which helped to ensure that only suitable staff were employed. Staff attended an induction when they started work and had access to on-going training.

People told us they enjoyed the food provided. They said they had a choice of dishes at each meal and had access to drinks and snacks outside mealtimes. People's dietary need were known by staff and support was offered to people in a dignified manner.

People and relatives told us that staff were caring. However ther were instances where people were not teeated with compassion. The permanent staff took time to communicate with people and ensure that support was offered in the way people preferred. Personal care was provided discreetly and people's dignity and privacy was respected.

There was a wide range of activities offered both within the community and when people were at home. There was a Masonic lodge at the service and the involvement of 'Friends of Shannon Court' ensured people were able to maintain their links with the masonic community.

People and relatives were regularly asked to give feedback on the service provided.

We identified a number of breaches 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

The service was not always safe.

Staffing levels throughout the service were not sufficient to meet people's needs in a timely way.

People were not always protected from the risk of avoidable harm.

People were not always safeguarded from the risk of abuse as staff did not always report concerns in a timely manner.

Medicines were administered and managed safely.

Appropriate checks were undertaken when new staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

People were supported by staff who were appropriately trained and competent to carry out their roles.

People were provided with food and drink which supported them to maintain a healthy diet.

People were supported to maintain good health and had regular access to a range of healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff supported people in a discreet manner and respected people's dignity and privacy.

Staff were kind and caring in their interactions with people. People were supported to maintain their independence.

People had positive relationships with the staff who supported them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records had not always been updated to reflect people's current needs.

Complaints were not investigated and responded to in a timely manner.

People were supported to take part in a wide range of activities and links with the masonic community were maintained.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of managerial support within the service.

Quality assurance systems were not always effective in identifying shortfalls within the service.

People and staff told us that there was a lack of communication and the culture could be more open.

Records were held electronically which had led to problems with access for staff.

The service regularly sought feedback regarding the quality of the service from people and relatives.

Shannon 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.

The inspection took place on 14 June 2016 and was unannounced. The inspection was carried out by three inspectors.

Before the inspection, we reviewed records held by the Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This was because we inspected the service sooner than we had planned to. 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.

As part of our inspection we spoke with the eight people who lived at the home, two relatives, seven staff, the deputy manager and members of the senior leadership team for the provider. We also reviewed a variety of documents which included the care plans for six people, five staff files, medicines records and various other documentation relevant to the management of the home.

The provider re-registered with CQC in April 2016 following a change in legal entity. However, the service remained the same with the same management team in place. Shannon Court was last inspected 11 August 2014 when we had no concerns.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they felt the service was safe although there were concerns relating to the staffing levels and high use of agency staff. One person told us, "Yes, I feel safe. I would tell them if I didn't." Another person told us, "I do feel safe but I felt better when there were more regular staff around." One relative told us, "I feel he's safe because staff are caring towards him but I do worry because they are so short staffed."

Sufficient staff were not deployed in all areas of the service to meet people's needs. People's opinions of the staffing levels provided in the service varied in different units. In one unit, which supported people living with dementia, relatives and staff told us they did not feel there were enough staff to support people's needs. One relative told us, "They are very short staffed." They went on to describe that people were frequently in the lounge without staff being present and that their family member had been left on the toilet for more than 30 minutes on at least two occasions in the past few weeks, "You ring the bell and they don't come." The staff members we spoke to confirmed that staffing levels meant that people needed to wait for care on occasions. One staff member said, "Sometimes we could do with another carer, I don't think two carers are enough, I will give up my break sometimes, I think there should be three (carers)." Another staff member said, "Some days we could do with an extra pair of hands."

During the inspection we observed people living in this unit were routinely left without staff support in the lounge and dining area whilst staff were supporting people with personal care. This indicated that people were placed at risk of harm as care staff were not always available to monitor their safety throughout the day. Staff told us this was particularly a concern when supporting people to get up in the morning, They told us, "We can't be in two places at once." A number of the people sitting in the area had been assessed as being at risk of falls and one person's care plan stated 'Never leave unattended'. During the afternoon we observed the person was driven to a health appointment by maintenance staff with no support from care staff. We were told this happened on a regular basis. We spoke to senior staff about this who agreed it was not appropriate for this person to attend appointments without care staff present due to their health care needs.

The deputy manager said that dependency assessments were completed monthly by care staff to establish the staffing numbers required in each unit. However, due to staff vacancies there was a high level of agency staff useage. The deputy manager told us that wherever possible they would avoid using agency staff to support people living with dementia and efforts were made to use the same agency staff to minimise the disruption for people. Due to the high cost of agency staff they told us that some agency staff would finish their evening shift an hour earlier when it was safe to do so. Rota's provided did not highlight where agency staff finished their shift early.

People told us the high level of agency use impacted on the care they received. One person said, "I just want someone to talk to but the regular staff are so busy because they're showing the agency staff what to do. When they finish early in the evenings it can mean there's only one person (staff) for over twenty rooms. It's lucky nothing has happened." Another person told us, "There's always new faces, I'm always having to

explain to them what I want, it can get tiresome." One staff member told us it was difficult working with agency staff on a regular basis although they did not believe this impacted on people's care. They said, "The agency staff are all really nice but it's time consuming having to train them. We swap tasks round so it doesn't affect people's care."

Failing to ensure that sufficient numbers of skilled staff were deployed in the service was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Within other areas of the service we observed that sufficient numbers of skilled staff were deployed. In the second unit which supported people living with dementia we observed staff were available to respond appropriately to people's needs and no one was left waiting for care. Staff told us they had time to spend with people and were not rushed when providing their care. One member of staff told us, "We get support from the domestic staff with breakfast and lunch. They do the serving and clearing up so that we can spend time with the residents. And the activities co-ordinators are here most mornings to do activities, which is really helpful." Where people had been identified as requiring one to one support we observed that people received this.

Staff were aware of their responsibilities in safeguarding people from abuse although some incidents were not reported in a timely manner. Records showed that staff had completed safeguarding training and the staff we spoke to were able to describe the action they would take should they suspect someone was at risk of harm or abuse. However, there had been a number of incidents identified where a person had assaulted other people. Although staff had informed relatives when they had visited, they had not reported the incidents to the manager or the local safeguarding authority. This meant that measures to prevent incidents of abuse had not been implemented in a timely manner. Once alerted to the concerns the registered manager had taken action to ensure the safeguarding team were informed, additional staff support was provided and that risk management plans were implemented. Additional staff training had been provided to remind staff of their responsibilities.

We recommend that the provider ensures that systems are in place to continually monitor that staff are aware of their responsibilities in identifying and reporting potential abuse.

Risks to people's safety and well-being were not always identified and effectively managed. One person's care file identified they were at high risk of falls. The control measure in place was to ensure the person always had their walking stick with them. There was no record of further control measures or guidance to staff as to how they should support the person when they were mobile . We observed the person was unsteady when walking and a visitor told us they had needed to support the person to prevent them from falling when no staff were available. Another person's file stated their leg should be elevated and that they required a pressure cushion at all times due to risks of skin breakdown. During the inspection the person's leg was not elevated and their pressure cushion was not used. The same person was witnessed to have a fall during the inspection, there was no falls risk assessment recorded in the person's care file. A third person's file showed they had experienced four falls since March 2016. The person's falls risk assessment had not been updated and control measures to mitigate the risks of the person falling were not recorded.

Guidelines or risk management plans were not always in place for people living with specific health conditions. For example, we viewed two people's files who were living with diabetes. There was no guidance to staff as to what support the individuals required in this area and no record of the condition within their eating and drinking care plans. Another person's file stated they could become distressed and anxious. There was no guidance to staff as to how to support this person with their anxiety.

The lack of effective risk management systems to protect people was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments within some people's files identified risks and had appropriate control measures in place. These included risk relating to falls, skin integrity, inadequate nutrition and hydration and moving and handling. Measures needed to address these risks had been recorded and implemented.

Good medicines management processes were followed. People's medicines records were up to date which meant staff would know when people had received their medicines. Each person had a medication administration record (MAR) which stated what medicines they had been prescribed and when they should be taken. MAR's included people's photographs and there was a signature list to show which staff were trained to give medicines. We found no signature gaps in relation to people's MAR's which meant people had been given their medicines when they required them.

Medicines were stored securely and at the correct temperature. There was documented evidence of destroyed and returned medicines as well as stock checks undertaken. Staff had a medicine policy providing guidance on the safe administration, handling, keeping, dispensing and recording of medicines.

People were protected by the provider's recruitment procedures which helped to ensure that staff employed were suitable to work at the service. Staff files contained evidence that prospective staff had submitted an application form with the names of two referees and attended a face-to-face interview. Prior to staff starting work the provider obtained references, proof of identity, proof of address and carried out a Disclosure and Barring System (DBS) check. DBS checks identify if a prospective staff have a criminal record or are barred from working with people who use care and support services.

People lived in a safe environment because checks of the premises and equipment were carried out on a regular basis and any problems were reported through the maintenance system. Records showed that the regular servicing had been undertaken of fire equipment and systems, portable appliances and gas appliance. A continuity plan was in place which detailed where people could be evacuated to in the event that the building could not be used and staff were aware of their responsibilities. This meant that disruption to people's care would be minimised should an emergency occur.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's legal right had not always been protected. We found that people's capacity to make specific decisions had not been assessed, which meant the provider could not be sure their care was being provided in the way they wished. There were no capacity assessments within people's care records to determine their capacity to make specific decisions. For example, one person who was living with dementia was supported to have a blood test during the inspection. No capacity assessment was recorded on the person's care file in relation to this.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).The deputy manager told us that DoLS applications had been submitted for people who required constant supervision and were subject to restrictions including key padded doors which prevented people leaving individual units. However, there were no records available to evidence that capacity assessments or best interest meeting had been held to determine the restrictions in place were required and were as least restrictive as possible.

Failure to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always have the opportunity to meet with their line manager on a regular basis which meant that not all staff's individual performance and skills had been formally reviewed. The provider maintained supervision and appraisal records which showed that a third of staff had not received supervision or appraisal meetings with the past three months, in accordance with the provider's policy. Staff told us that senior staff within the service were supportive and felt they could raise any urgent concerns with them.

The lack of support for staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were inducted into the service and received training to support them in carrying out their role. One staff member told us, "I'm more than happy with the training. I think we have all the training we need." Another member of staff said, "I can't fault the training." Records showed that staff completed an induction programme when starting work at the service and were given the opportunity to shadow more experienced staff members. The provider maintained a training matrix which identified the date staff had completed

training and when refresher training was required. Records showed that staff had received mandatory training which included moving and handling, safeguarding, health and safety and first aid. In addition, staff working with people living with dementia had received specific training in this area. One staff member told us this had taught them the importance of adopting a consistent approach to caring for people living with dementia.

People told us that the food was good and that they had a choice of meals. One person said "The food is good here which is important." Another person told us, "The food's good and too good, I've put on weight here." People said they were always asked about what they wanted to eat and people living in the dementia units were offered a visual choice of meals. We observed that the atmosphere during the mealtime was relaxed and that staff made sure people were happy with the meals they had chosen. People were offered a choice of drinks with their meal and snacks were available throughout the day.

Where people had been assessed as requiring a soft or pureed diet we saw this was provided and staff were knowledgeable about people's individual needs. Staff ensured that people who required assistance to eat and drink received this support, giving people time to eat at their own pace and to enjoy their meals. People's weight was monitored regularly and action taken when significant changes were noted.

People had access to external healthcare professionals and received the healthcare support they required. People's care plans demonstrated that their healthcare needs were monitored and addressed. There was evidence that people saw healthcare professionals when they needed to and that any guidance put in place was included in their care plans. People told us they were supported with their healthcare needs, one person said, "They always make sure I see a doctor if I need to. They are magnificent really." We observed one person complaining of pain. Staff asked the person if they wanted painkillers and checked the person's 'as required' medicines protocol prior to administering them. Another person appeared unwell and an appointment was made with the GP. However, it was thought the person needed to see a doctor more quickly, the deputy manager ensured that the appointment was brought forward.

The premises were decorated and furnished to a high standard and communal areas were comfortable and homely. The units supporting people living with dementia were bright and open with chairs arranged in small clusters. People's rooms had memory boxes containing items personal to the individual outside their door to help them identify their room. Items of interest and sensory items were placed around the communal areas and corridors for people to use. There was a large board displaying the day, date, time and weather to help to orientate people. Carers supporting people living with dementia did not wear uniforms so as not to make people feel they were in a clinical environment.

Good

Is the service caring?

Our findings

People and relatives told us that despite the high use of agency staff they felt staff were caring. One person said, "They're marvellous, very nice, lovely people. Everybody here is kind." Another person said, "Nothing is too much trouble for them." One relative told us, "The staff are never nasty or cross, they are very encouraging to him."

Staff interacted positively with people and the atmosphere in the service was calm and relaxed. Staff took the time to ask how people were and if there was anything they needed. For example, we observed one person walking with a staff member, they were chatting easily and laughing together. Another staff member noted that someone was rubbing their arms. They asked the person if they were cold and brought them a cover to keep them warm. Housekeeping staff were observed to chat easily with people when they were cleaning in their rooms.

People were supported by the permanent staff who knew them well and used a range of methods to support communication. One person had communication difficulties due to their hearing loss. Staff had developed a range of written cards to help them communicate and ask the person questions regarding their preferences. We observed staff singing to people as a way of communicating with them which they reacted positively to. In the units supporting people living with dementia staff showed people options available to them such as drinks and activities to enable them to make a choice. However not all agency staff knew people well, although they were kind they were unable to respond to people in a meaningful way at all times because they did not know their history or background. This is especially relevant for people living with dementia. We observed an agency staff member arrive for an afternoon shift on one unit supporting people living with dementia. They sat in the lounge area but did not greet or acknowledge any of the people sat alongside them.

Staff told us they aimed to provide a flexible service to people. One member of staff said, "It's very flexible for them. They might have been up all night and need a sleep in the morning. We make sure they have choices. They can have whatever they want, when they want. If they want food outside mealtimes, we have a kitchen here and we can always make them something." During the inspection we observed that people were able to choose the time they got up and when meals were provided. Where people chose to eat in their rooms meals were provided promptly and we observed two people who preferred to eat together were provided with a private area where they could sit. We observed that when people asked staff to come back at a later time this was respected.

People's privacy and dignity was respected. Throughout the inspection we observed staff knock on people's doors and wait for a response before entering. When supporting people with personal care this was done discreetly and doors were closed to maintain people's dignity. We heard one person ask a staff member if they could wipe their mouth for them. Staff did this discreetly and chatted with the person quietly. One person told us, "Staff always knock, they're polite and respectful." Staff told us they understood the need to maintain people's dignity, "It's really important, we never want to make people feel uncomfortable. I will always knock on doors, make sure curtains and doors are closed when I'm doing personal care and that

they're covered as much as possible."

People were supported to maintain their independence. One staff member told us, "That's the reason I would be happy for my parents to live here. Staff don't take people's independence away. We always ask people and encourage them to do things for themselves." We observed people were able to maintain past routines such as setting tables for lunch and washing up. Where people required aids and adaptions to assist them in remaining independent these were provided. For example, at lunchtime people were provided with adapted cutlery and crockery to enable them to eat independently.

Visitors were welcome at the home at any time. The deputy manager confirmed visitors were welcome at any time and there were a number of smaller lounges and communal areas available should people not want to meet visitors in their rooms.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were not routinely involved in developing and reviewing their care plans. One person told us, "I asked about my care plan reviews, I haven't seen it for six months and it should be done monthly, I was told it was done monthly and I didn't need to see it. The deputy said this was wrong but I still haven't seen it." Another person said, "I've never seen one, I'm not sure what it would say." One relative told us, "I know there is one but I haven't seen it, they seem to get things right though."

Care plans and reviews were not always completed in a timely manner which meant staff did not have up to date information regarding the care people required. One person told us, "It took nearly a year to complete." A relative told us, "It took a long time before they said the care plan was complete and I still haven't seen it." They added that it had been recommended that their family member was supported to take regular short walks but they had not observed this happening. We found that there were still gaps in the person's care plan and the summary of care required lacked detail. The need to take regular walks had not been identified and records did evidence this was happening. Another person's care plan had not been updated for three months and referred to the person using mobility aids which were no longer suitable for them. The person told us they had significant concerns relating to their mobility and the support they received which had meant they had been unable to leave their room for over three weeks. There was no records contained within the person's care file relating to their changing needs or guidance to staff on how to support the person to ensure they did not become isolated.

The provider's recent internal audit also identified gaps in the recording and review of care plans. The report concluded that although areas of good practice were observed, 'the concerns identified in care plans and staff interventions do not demonstrate residents safety is satisfactorily maintained; in addition records and risk assessments do not consistently reflect current needs, and were not adequately reviewed. Staff had clearly spent a great deal of effort in completing care plans, but in many instances these contained irrelevant or conflicting information, and did not demonstrate staff were responding adequately to peoples changing needs'. Following the inspection the registered manager forwarded an action plan which detailed how the concerns raised within the audit would be addressed.

The failure to ensure care plans were in place and care delivered which met people's individual needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care plans we viewed contained detailed guidance for staff to follow and were reviewed regularly. All care plans contained personalised information and included details about people's life history and what was important to them, this included people and events that were significant to the person as well as their interests, hobbies and preferences. During the inspection we observed staff using information regarding people's family members to initiate conversation.

Complaints were not always recorded and acted upon in a timely manner. Three complaints were logged within the complaints file, two of which related to staff conduct and one relating to staffing levels. One complaint had been received in March 2016 and a second in April 2016. There was no evidence that the

complaints had been investigated or responded to.

The failure to act upon complaints received was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A wide range of activities were provided, both within the home and in the local community. People told us they enjoyed the activities on offer. One person said, "Always something to do and they make it enjoyable." Another person told us, "I prefer to keep myself to myself but they bring me a list of what's happening every week in case I want to go along." One relative told us, "They are good at activities, something for everyone." The activities programme included a mix of trips out to places of interest and locally to shops, pubs, theatres and garden centres. There was a Masonic lodge at the service and visits were arranged to other lodges, which enabled people to maintain their contact with the Masonic community. A voluntary group, 'Friends of Shannon Court', organised regular events at the service including a ladies night, golf day and a garden party. The group also raised funds for activities throughout the year.

The activities co-ordinators told us the bar was well used for social events. We observed that people used the bar to have a drink before lunch and staff told us this happened every day. People were involved in the planning of activities, one person designed the questions for the weekly quiz and another person ran a bingo session. During the inspection a number of people went out to visit Hayling Island supported by staff. People who remained at the service were involved in a range of activities including reading, puzzles, jigsaw s, listening to music and playing board games.

Requires Improvement

Is the service well-led?

Our findings

People and their relative's opinions of the management of the service varied. Some told us they had concerns as the registered manager was not always present which did not give them confidence in how things were being managed. One person told us, "We never see him, even when he's here we don't see him." Another person said, "He swoops in and swoops out, he's alright I suppose." A relative told us they visited the service daily and had only seen the manager once in over two months, "It doesn't give you confidence." People spoke highly of the deputy manager, they told us, "Very efficient and keeps things going." Another person said, "They do their best but it's too much to expect of one person."

There was lack of managerial presence and oversight of the service. The registered manager was also responsible for the management of another service which meant their time was split between two locations. The deputy manager told us this meant the registered manager was at the service on average two days per week, "It depends what is happening, sometimes it can be more, sometimes less. I'm always able to contact him if there's a problem or if I need advice." The service also had a vacancy for a second deputy manager which they had been unable to recruit to at the time of the inspection. Staff told us they felt there was a lack of support from the registered manager due to their commitments. One staff member told us, "He is not around much. I think he needs to be here more. We don't know when he will be in. Relatives come in and sometimes they want to speak to the boss. They ask us when he will be here and we have to say we don't know." Another member of staff said, "The manager's not here very often and I think he needs to be. He's not really built a rapport with the staff or the residents." During the inspection, senior staff from the organisation informed us that the decision had been made to recruit a full-time manager at Shannon Court. They told us that although they had complete confidence in the registered managers skills they believed that managing two services was too difficult for one manager.

Systems designed to monitor the quality of the service provided were not always effective in identifying areas which required improvement or taking action to do so. Senior staff were responsible for conducting monthly audits within the service and an annual audit was completed by the organisation's quality assurance team. We found that areas of concern had not been consistently identified through the auditing processes. For example, monthly care plan audits had not identified any of the concerns although these had been highlighted both within the inspection process and during the provider annual quality audit. Accidents and Incidents were reviewed but had not identified the concerns relating to one person assaulting other people or the high levels of falls experienced by one person. The monitoring of complaints had not identified the lack of response to complainants and had not resulted in action being taken to rectify concerns relating to staffing levels and the furniture in the dementia unit being moved.

People and staff told us that they felt the culture of the service should be more open and communication could be improved. One person told us, "We used to have regular residents meetings but these don't happen as often as they should. When the deputy manager was promoted we weren't told. I only knew because I saw it on their badge." Staff told us that the registered manager did not promote effective communication or encourage staff to contribute to the development of the service. One member of staff said, "I've never been to a team meeting." Another staff member told us, "Staff meetings rarely happen,

communication's not his (registered manager) cup of tea." We found that two staff meetings and one residents meeting had taken place since June 2015. Staff told us the deputy manager tried their best to keep up with what was happening in the service by regularly talking to people and having lunch with people. Minutes of the meetings identified they were used to pass on information rather than to discuss changes and ideas for service improvement.

Records relating to people's care were not easily accessible which meant staff did not have consistent access to people's care plans. Records were stored electronically with access to laptops provided for staff throughout the building. During the inspection we were unable to access care records on several occasions due to poor internet connections and in one area had to wait for 40 minutes for the system to connect. Staff told us this was a frequent problem. One staff member said, "It's not always possible to get into the system because of the internet connection. Sometimes we write notes but when we go back in they haven't saved." Another staff member said, "We get there in the end but we sometimes have to move around the building to get a connection." Other records relating to the service were accessed upon request and paper records were stored securely. Not all care records were accurate, up to date or contemporaneous in recording people's needs and risks. Therefore, staff did not have access to the most current information they required to deliver effective care.

The lack of effective systems to ensure good governance and accurate records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback relating to the quality of the service was gained from people and their relatives. An independent survey was undertaken on behalf of the service on an annual basis. The results of the latest survey showed a high level of satisfaction with the service from both people and residents. Where concerns had been identified the registered manager had implemented an action plan to address these.

The registered manager had a good understanding of their legal responsibilities as a registered person, for example sending in notifications to the CQC when certain accidents or incidents took place. Policies and procedures were in place to support staff so they knew what was expected of them. Staff told us they knew where the policies were kept and could refer to them at any time.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that care plans were in place which reflected people's needs

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that effective risk management systems were in place to protect people from harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure systems were implemented to act upon complaints received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	The provider had failed to ensure that systems were effective in monitoring the quality of the service provided and that records were accurate, up to date and easily accessible to staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure there were sufficient numbers of staff deployed. The registered provider had failed to ensure staff received appropriate support.