The Royal Masonic Benevolent Institution

Devonshire 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out a focused inspection on 23 February 2016 because we had information of concern relating to the safe care and treatment of people living at Devonshire Court. After our focused inspection we decided to conduct a full comprehensive inspection on 2, 3 and 4 March 2016

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 59 people using the service on the day of our inspection visit.

The service did not have a registered manager. 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 one of the Regulations of the Care Quality Commissions (Registration) Regulations 2009. You can see at the end of this report the action we have asked them to take.

Safeguarding concerns, incidents and accidents had not been reported appropriately and consistently. Not all accidents or incidents were reported or investigated. Where people displayed behaviour that challenged others, staff had not been given clear guidelines about how to support those people and prevent risk of harm to them and others

People could not be sure that they would receive their medicines as prescribed by their doctor. We saw people's medicines were not always administered correctly. Medicines were not always stored safely in people's rooms. Medicines records were not always accurate and systems to check medicines were not robust.

We found that money was stored appropriately but that access to money by people and staff required greater security measures to avoid the risk of people's money being misused.

There was a recruitment policy in place which had been followed. This ensured that all relevant checks were

carried out on staff members prior to them starting work. Some people that we spoke with felt that there were enough staff to meet people's needs but felt that staff were very busy. The service was relying on a high number of agency staff to fill vacant care worker positions. People told us that not all staff knew how to meet their needs.

Where people were at risk of falls, appropriate assessments of their needs were not always undertaken.

Most risks associated with the environment, care routines and equipment used to support people had been assessed and hazards were identified. Measures were in place to prevent harm. Fire equipment testing had been carried out but not all staff were aware of the action they should take in a fire or how to support people to evacuate safely.

The provider had not ensured that the requirements of the Mental Capacity Act 2005 were being met. Where people were assessed as lacking mental capacity to make decisions for themselves best interest decisions had not been made for them.

People were not always supported to maintain good health. Where risks to people's health had been identified appropriate measures had not always been put in place to manage the risks. People had access to health care professionals but the records regarding their health care needs were not always clearly maintained

Staff received supervisions and we saw that there was a programme of ongoing training to ensure that they had the knowledge and skills they needed to meet people's needs. The support that people required to have their needs meet was not always clearly documented. Staff were not always clear on how to record people's needs or support that they had received. Where people's needs had changed this was not always clear in their care plans.

We received mixed feedback about whether staff were kind and caring. Most people told us that they were treated with dignity and respect but some people said that they were not. We observed staff interacting in a caring manner with people who were distressed or upset.

People were supported to maintain relationships with people who were important to them. People were supported to follow their interests and engage in activities.

People were not always involved in making decisions about their care, treatment and support.

People told us that they were asked for feedback about how the service was run. Complaints were not always recorded and dealt with in line with the provider's policies.

There was not robust monitoring of significant events, such as injuries, 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

People using the service and relatives were not clear on who the manager was. Staff felt supported by the new management structure.

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 consistently safe

Safeguarding concerns, incidents and accidents had not been consistently reported and some had not been reported to the local safeguarding authority as they should have been.

People were not always given their medicines correctly.

Risk assessments did not always protect people from avoidable harm.

Is the service effective?

Requires Improvement

The service was not consistently effective

The provider had not ensured that the requirements of the Mental Capacity Act were being met.

Not all staff had all the information they needed to support them to meet people's needs.

People were supported to eat maintain a balanced diet.

People were not always supported to maintain good health.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff were not always caring and did not always treat people with dignity and respect.

People were not always involved in making decisions about their care, treatment and support.

Staff interacted with people in a caring manner when they were distressed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

The support that people required to have their needs meet was not always clearly documented.

People were supported to follow their interests and engage in activities.

Complaints had not always been dealt with in line with the provider's policies.

Is the service well-led?

Requires Improvement

The service was not consistently well led

The provider's audits had not always identified areas that required improvement.

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

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 carried out a focused inspection on the 23 February 2016 in response to concerns we had received about the care and treatment of people living at Devonshire court. After our focused inspection we decided to conduct a full comprehensive inspection on the 2, 3, and 4 March 2016

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 to 14 people and 8 relatives of people who used the service.

We looked at the care plans and care records of 14 people who used the service at the time of our inspection. During our inspection we spoke with staff members employed by the service including the cook, a domestic member of staff, an activities coordinator, a catering assistant and nine care workers employed by the service. We also spoke to the newly appointed interim manager and the regional operations manager who was working at the service to oversee the daily running of the service. We also spoke with two staff who were working at the service who had been supplied by a care agency. We looked at five 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 evidence of staff training.

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 dealings 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.

Requires Improvement

Our findings

The provider had a policy in place that provided staff, with details of how to report safeguarding concerns. Staff were aware of this policy and how to report and escalate issues and incidents if required. They told us that they felt able to report concerns. The regional operations manager was aware of their duty to report and respond to safeguarding situations. However we identified six incidents that had occurred when no alert to the local safeguarding team or police had been made when they should have been. These included situations where people had fallen resulting in serious injury and where one person using the service had injured another person using the service. Staff had recorded such occurrences on accident or incident forms but these had not been reviewed by the senior management team and appropriate action had not been taken to prevent further harm. This meant that people were not protected from abuse and improper treatment.
We found that money was stored in the main safe. We found that there was not clear agreement or guidelines to inform staff or people who used the service about who could access people's money. People's finance records were audited annually. Informal checks had taken place but these were not recorded. This meant that there is a risk that there would be a delay in identifying any discrepancies. We looked at the service's finance policy. This was dated 2005. We were told that this had been reviewed more recently but a copy was not available at the home. After the inspection the provider advised us that they planned to carry out a full audit of the finance systems and that they intended to implement more robust checks in the future.

These matters constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood that they were required to report accidents and incidents and confirmed that they were required to fill a form in. We saw that there had been times when that incidents and accidents had not been reported appropriately and consistently. For example we saw that on one occasion a person using the service had been found behind a locked door. There was no detail about the circumstances to indicate why the staff member had recorded this as an incident. There were times when incidents were recorded on people's behaviour charts and no incident and accident form had been completed and no further relevant action had been taken. This was discussed with the regional operations manager who acknowledged this was an issue and has arranged for changes to be made to the IT system and for a staff meeting to be held to discuss recording with staff.

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. Staff used an Electronic Medication Management system (EMMS) to tell them which medicines to give people. Staff made a record in the electronic Medicine Administration Record (eMAR) when they administered people's medicines.

People could not be assured that they would receive their medicines as prescribed by their doctors. Their medicines were not always administered or managed safely. For example we saw that staff did not follow appropriate hand hygiene practice and we saw that staff had administered medicines to people without carrying out the correct health care tests to ensure that it was safe to do so. We also saw that a pill crusher was in use which contained the residue of other people's medicines and that there had been times when people had not had their medicine because they had run out. Some medicines were also not always stored at the right temperatures or disposed of when they became out of date. This meant that people could not be assured that they would receive their medicines correctly or that their medicines would be effective or safe.

When people did not take their medicines as prescribed, staff did not record the reasons for this. This meant that the provider could not properly monitor their health needs.

Some people were prescribed medicines to be taken only 'when required'. However, there was no guidance for staff on the circumstances when these medicines were to be used and offered to people. The same was the case for the application of topical creams. There was a risk therefore that people would not receive the medicines that they needed.
The service had undertaken full monthly and daily audits to try and address some of the medicines concerns. The audits had not identified all of the failings we found in their current practice.
The interim manager immediately corrected some of the matters relating to medicines and assured us that they would address the other matters urgently.
People were at risk of harm from other people's behaviours. Staff were not always clear of how to support people whose behaviour challenges others. Some staff were not aware of the challenging nature of people's behaviours. We looked at people's care plans and found that information about how to support a person when they were anxious or displaying behaviours was not clear. For example a staff member told us that one person became upset and displayed behaviours that challenge when their spouse left after a visit. We found no mention of this or guidance in their care plan. We reviewed incident records and found a number of incidents relating to behaviours of service users that challenged both staff and other residents. Some of these incidents had resulted in harm to other people who used the service. The regional operations manager informed us that they had planned training for all staff over the next few months to address challenging behaviour and that care plans were being reviewed to include information about people's behaviours.

We saw that the provider had written a falls policy in February 2016. This detailed the actions staff should take after a person had a fall and what measures could be taken to protect the person from falls in the future. Some people had been assessed as being at risk of falling but it was not clear what the nature of the risk was. We saw that for these people equipment or additional staff observations had been put in place but it was difficult to judge if these measures were suitable to reduce the risk of harm if people fell. When people had fallen risk assessments and strategies to prevent falls had not been revisited to ensure that they were still appropriate to meet their needs.

One person told us that they didn't have the equipment they needed to help them stay safe. They said, "[staff] put me on a shower trolley from my bed but it's not designed for bent legs. Once a man was pushing me through the door and forgot to hold my knee and it bashed against the door – I was tempted to swear"

These matters constituted a breach of Regulation 12 (2) (a,b,c and g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a recruitment policy in place which had been followed. This ensured that all relevant checks were carried out on staff members prior to them starting work. We looked at the recruitment files for four staff members. We found that all the required pre-employment checks had been carried out before they had commenced work.
Some people that we spoke with felt that there were enough staff to meet people's needs but felt that staff were very busy. One person told us, "I ring my bell and they know I'm ready for them. They always come." Another person said, "They come within minutes" But other people told us that they did not feel there were always enough staff. One person said, "Sometimes it's quick but it can be up to 20 minutes at times." A relative told us "The girls come fairly quickly but one day it took 30 minutes just when she needed the commode, so by the time they came it was too late." Staff told us that they felt there were enough staff but that they hoped staffing levels would increase if more residents required support. One staff member told us that they felt the shift leader needed to be supernumerary so that they could concentrate on the medication and admin tasks. Another staff member said "There are usually enough staff but because people can be unpredictable sometimes it is a struggle." They went on to say that under the new management if they reported they were struggling staff would be moved from another area of the home to help. The regional operations manager told us that they were reviewing the staffing deployment at night. This was to ensure the correct staffing levels were in place.

Risk associated with the environment and equipment used had been assessed to identify hazards. Measures had been put in place to prevent harm. Where regular testing was required to prevent risk, such as electrical safety testing, this was recorded as having happened within the required timescales. We identified two areas of risk posed by the physical environment. These were hot water urns in the smaller dining rooms on individual units and where window restrictors required further assessment. When we returned on the 2 of March we saw that the regional operations manager had taken measures to address these risks.

The help that people would need if there was a fire was not regularly assessed. The regional operations manager informed us that they were in the process of reviewing these assessments and ensuring that they were available to all staff. Fire equipment safety checks were carried out and there were procedures in place for staff to follow but staff were not always clear on these procedures. We were unable to find a record of a recent fire drill. The regional operations manager informed us that they would ensure that one was carried out by the end of the month. There was a business continuity plan in place to be used in the event of an emergency or an untoward event. Regular servicing of safety equipment used was undertaken. This was to ensure that it was safe.

Requires Improvement

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

We found that people were not always being supported in line with the Act. The MCA requires that people's capacity to make decisions is assessed on a decision by decision basis. We found where people lacked capacity, best interest decisions had not been made as required. This was confirmed by senior staff at the home. We found for example that there were occasions when people had been supported in bed with rails that would prevent them from falling out of bed. If people were not able to make an informed decision about whether they were content to have bed rails then this would have needed to be authorised under DoLS. We found that there were occasions when the use of bed rails had not been authorised. Where DoLS applications had been made these had not always been done so in a timely fashion and there had been times when an application had been made at the request of the local authority. We found that staff at all levels within the home did not have a clear understanding of their responsibility under the MCA. Training records indicated that not all staff had received training about the MCA and where they had they had many not received refresher training since 2013. The regional operations manager told us that training had been booked for all staff to attend over the coming months.

These matters constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff felt that they had received training to enable them to meet people's needs. We reviewed staff training records and found that most staff had received relevant training in order for them to be able to have the right skills and knowledge to meet people's needs. The operations manager had identified where people had not received the appropriate training, for example where staff required greater knowledge

around dementia and was arranging for these courses to be delivered over the next few months.

We reviewed supervision records and saw that staff received supervision from senior staff. One staff member told us "[senior staff] is good, she is on the ball with supervisions." The acting manager was in the process of ensuring that all nursing staff received clinical supervision and competency checks. We were told that all staff were due to attend group supervisions where their roles and responsibilities were to be outlined.

The service was relying on a number of agency staff to fill vacant care worker positions. People told us that not all agency staff knew how to meet their needs. One person said, "The agency staff don't know me and I have to tell them not to move my legs." Another person said, "Definitely [permanent care staff] have the skill. The agency ones are the ones not so au fait with things" and a third person told us, "The agency aren't very good. They don't know us or the place." Permanent care staff had similar views. We looked at the rota and saw that agency staff were employed within the service on every day over a six day period in February 2016. The regional operations manager informed us that they had spoken with the agency and had requested to block book preferred staff members to aid consistency and quality.

We saw that meals could be taken in people's bedrooms, the main dining room or smaller dining rooms on individual units. The majority of people told us that they enjoyed the food. One person said, "It's excellent! There's always two mains and options – I ask for a salad sometimes" and other said, "I eat what I want. It's very nice. Other people told us that, "It's just ok. I miss the fresh fruit and veg. There's lots of stodge." A person who took their meals in their room told us that their food was, "usually tepid or cold." We observed people eating in the main dining room as well as the unit dining rooms and saw that people were offered a choice of two meals. Menu's on the tables and displayed outside the dining room indicated that a choice of at least two options were available at each meal time. We observed that robust food hygiene checks had not been carried out in the unit kitchenettes. For example, food had not been labelled when it had been opened. This meant that people could not be confident that it was still safe to eat. We discussed this with regional operations manager and found that this had been addressed when we returned on the 2 March. People told us that drinks were readily available and hot drinks trolley visited bedrooms twice a day. We observed this to be the case.

People were not always supported to maintain good health. Where risks to people's health had been identified appropriate measures had not always been put in place to reduce the risks. We found that assessments for people who were at risk of developing pressure sores were not always carried out in the timeframes that they should have been. We also saw that inaccurate assessments of the risk to one person had been made. Where people were identified as prone to urinary tract infections (UTIs) and needed prompting with drinks, fluid balance charts were not consistently filled in. The service had introduced combined fluid charts at the beginning of the year to help make fluid input charts more meaningful. We were told that fluid balance charts were reviewed by the nurse every night but these discrepancies had not been picked up. We also found that were people were identified as being at risk of malnutrition and weight loss they were not always monitored as they should be. We saw discrepancy's in records and there were times when there was a delay in contacting the relevant health professionals when people had lost too much weight. We also saw that there were gaps in records when people needed to have their blood sugars measured.

People told us that they had access to health professionals and regular check-ups. One person said, "I go to the dentist just across the road and one of the girls will take me. I had a visit from an optician a while back. The chiropodist is about every six weeks." We saw that the service had contacted a variety of health professionals to attend to people's health care needs. We found that there were occasions when the

contacting of health care professionals had been delayed, for example where a person who required their urine output to be monitored. In this case the output was monitored but the low reading had not alerted staff to contact medical help until the person had begun complaining of pain.

Requires Improvement

Our findings

Some people told us that staff were caring. One person said, "They're all very kind and caring" another said, "They're very kind and nice" but other people told us that care staff are usually too rushed to spend any length of time with them or chat for long. One person said, "They have been short staffed to spend time. My named carer spends a bit more time if he's on." Another person said, "They don't have much time." Another person said, "No-one spends time with me" and "There's mainly someone around but they're so often rushed." During our inspection we did not see staff sitting with a resident for any length of time or spending time chatting however we did observe some staff interacting with people in a kind and caring manner. During the lunch-time medicine rounds we saw a nurse and four staff administer medicines throughout the service in a kindly manner. We observed some staff knew people well and understood the things that they enjoy or their preferences. For example one person said, "I get my hair and nails done in the salon – we've got two girls there."

We observed staff interacting with people who were distressed or upset. We saw when one person became distressed a staff member immediately responded to them by showing concern and empathy and engaged them in an activity. The person had already taken their maximum dose of pain relief but was still complaining of pain. The staff member continued to engage with them and offer a range of board game activities that they appeared to enjoy to distract them from the pain. We saw other occasions when staff distracted people or offered alternative activities to people to help them keep focused on positive interactions.

Most people told us that they were treated with dignity and respect. One person said, "Yes, normally they knock and are kind". People confirmed that curtains were drawn and the door closed when personal care was being carried out. One resident told us that she always liked her curtains open day and night and this was respected by the carers as their room was not overlooked. Staff understood what was required of them to ensure people's privacy and dignity was maintained. One staff member told us, "I treat the rooms as if its flats. Ask if I can come in and make sure people are covered up. Keep things private." But other people told us "The night staff can be a bit off – don't knock and just walk in." Another person said "They check on me at least every hour. They can't reposition me but they see that I'm okay – but they will put the light on and off at night. I don't sleep well at the best of times." Another person said, "When I'm in the shower, it only reaches half of me, so they wash that bit then turn me round and do the rest, by which time by first half is cold." During our inspection we observed that when people were being provided with personal care and treatments their bedroom doors were closed. We observed staff knock and await a response before entering people's rooms.

We saw that people were supported to maintain relationships with people who were important to them. At lunchtime we observed staff supporting people to be as independent as possible. One staff member told us, "We promote independence to keep [people] active." Family members were encouraged to support mealtimes and could also have a meal with their loved ones. For those people living with dementia they were shown the two menu choices plated to help them make decisions. We saw that decorations and items were used to help people with dementia orientate themselves to their surroundings and offer additional prompts to help people understand what was happening or what was expected of them.

People were not always involved in planning their own care. We received mixed comments on the topic of seeing care plans and feeling involved in care. Some people told us that they had been involved. One person said, "I realised I can look at them [care plans] now. I had a review recently with a doctor about end of life and so on. I've not seen a care plan yet – but I'm happy it doesn't need checking." Another person said "I've seen it I think. It's in my cupboard". But other people told us, "I don't know anything about a care plan." A relative told us, "No, I haven't been involved." Care records we looked at did not include evidence that people had been involved in their care. We were made aware by the regional operations manager that the management team was in the process of reviewing and updating care plans and involving people in the process. This was confirmed by a family member who said, "Funnily, maybe it's because they knew you were all coming but I've only just signed a new one two days ago."

People were supported to have a dignified death in line with their wishes. We saw that Do Not Attempt to Resuscitate (DNAR) forms, were retained within residents' individual rooms; secured in the personal medication cabinets. We were told that staff were alerted to a DNAR being in place by the use of a red sticker affixed to the door of the medication cabinet in the resident's room. We saw this sticker in place in people's rooms. We looked at the forms and found that they were appropriately completed by their GP, as lead clinician, and confirmed discussion with others.

Requires Improvement

Our findings

People did not always have their support needs sufficiently well assessed before they came to Devonshire Court to be assured that their needs would be met. We saw both electronic and paper assessment records and found them to be incomplete and lacked enough detail to support robust care planning.

The support that people needed to have their needs meet was not always clearly documented. The care planning documentation was however person-centred. The care files were comprehensive and structured in the form of "care domains", which included information about the support that people needed as well as people's likes, dislikes and preferences and aspirations.

Care plans were in place and there was some evidence that they had been reviewed and updated although this was not always undertaken in a timely fashion. For example, we looked at the care documentation for a person who had been discharged from hospital with a diagnosis that the staff team would need to understand and know how to manage. The documentation had not been updated to give staff this important information.

We saw that there had been times when some people had refused care or chosen to not take advice about how best to manage their condition. This had been supported and recorded in the care plans. In some care files it was documented the gender of the staff people would like to provide their care.

The care files were computer based. This meant that staff needed access to a computer to identify the care required and for updating. Whilst the computer record was quite lengthy, each individual resident's file contained "Summary Care Plans", which provided an overview to support staffs understanding of people's needs. Staff told us that they found recording in care plans to be time consuming and not always easy to navigate. It was not clear within the care records how individual risk assessments were linked to care needs as these were stored away from the care plans within the electronic care planning system and had to be viewed independently to the care plan. One staff member said, "I don't know what I should be doing or where I should record things."

We also noted that routine procedures such as urinary catheter changes which would be the responsibility of the community nursing service were recorded by different staff in different places. Depending which area of the electronic care system was being looked at it was not clear if had been done or was needed. We discussed this with the regional manager who confirmed that they system was being stream lined and that

staff were all receiving additional training to us the system.

Staff felt they were kept well up to date through handover if people's needs changed. We attended handovers and information about people was detailed and changes to people's conditions was shared. We spoke to staff about how information about people's changing needs is communicated. They confirmed that this happened at handover but that there was a chance information could be missed if staff had been on leave or missed the handover. The regional operations manager told us that if staff have been away for some time they receive an extended handover.

People were supported to follow their interests. A person told us "I'm never bored. I like the quizzes and musical movement. We have a little library here too. The outings are good – we go to things like a pub meal, the park, a garden centre or a run round the countryside. The volunteers are very good here." Another person said, "I love the music movement! I don't really get bored here."
We were told by one person's relative that their relative had missed activities in the morning as staff had not supported to get ready in time. Another person told "I get bored at weekends though as there's not a lot on then."

There was a team of activity organisers and a dedicated noticeboard by the dining room had a display of all forthcoming events for the people using the service. We saw activity time tables were also displayed in other parts of the home. We saw that monthly booklets were produced to inform people of events and activities. National celebration days and resident birthdays were celebrated. A monthly booklet 'Devonshire Cream' was produced by the home and provided people with a timetable of activities day by day as well as quiz pages and topics to read. The home has two minibuses for outings and a number of volunteers are involved to support people accessing activities in the community. During our inspection we observed that there was a well-attended musical movement session in the conservatory run by the activity staff. We also observed a poetry session, a pet therapist visit and a reminiscence session. We also observed that people we supported to access a church service and communion held in the dining room with a visiting minister. For those residents who did not wish to attend the service, there were plans for the services to be filmed so that they could take part and watch from their own bedrooms.

People told us that they were asked for feedback about how the service was run. One resident told us "There's quite a lot going on. They always ask us for our suggestions." Another person told us "I'm on the residents meeting committee and we had a health and safety meeting - I mentioned about a cupboard door in the little kitchen that juts out. But they can't change it apparently." The chef told us that they got feedback from residents meetings about people's preferences and they had information about people's likes and dislikes in a file. The lounge was in the process of being redecorated at the time of our inspection. People told us that they had been involved in the redecoration plans. We saw meeting minutes that confirmed that residents and relatives had been informed of events and their opinions sought.
People told us that they had not always been consulted about changes to the home that affected them. For example the resident's kitchen was no longer available for all residents to use as a lock had been fitted to the door. Some residents told us that this had caused them frustration and that they were not clear about why this had been done. We discussed this with the regional operations manager who said that the kitchen had been locked as a result of a request from local authority.

The provider had sent out a survey to establish people's feelings and experiences about the service that they received but the results had not yet been collated or an action plan put in place to address any concerns identified.

Concerns and complaints were not always encouraged and responded to. One person told us, "I complain all the time. We've had problems with the baths and showers – something about they put new heads on the showers and not enough pressure to work it." A relative told us "I've had to complain twice lately. I've had no follow up or apology from the manager." Another person said, "There's been a bathroom crisis for some reason – her hair got lanker as she was weeks without a shampoo. There was no explanation until I got a bit grumpy – as they don't do anything for you unless you ask. It seems to be sorted now anyway." We spoke to regional operations manager who provided us with a log of complaints. The operations manager confirmed that the log did not accurately reflect the number of complaints received. The complaints procedure was not always followed in line with the providers policies. We were told that when people came to live at the service they received a 'Welcome handbook' which contained the complaints procedure. We saw that the service had a complaints procedure but this was not prominently displayed. After our inspection we received confirmation form the provider that the complaints procedure had been moved and was clearly displayed in the home foyer.

Requires Improvement

Our findings

The provider conducted bi-annual internal audits around the safe running of the home and care and treatment of people. We saw records from an audit that had been completed in November 2015. We saw that issues around staffing, care records, communication between staff and management and staff understanding of MCA had been identified as needing attention. It also identified that monthly audits of care and medication systems were not being completed. The provider had not yet addressed these issues. We were told that the provider intended that the regional operations manager should carry out bi-monthly monitoring visits. The last two of these visits had been nine and 19 months before our inspection.

We found that there was no robust monitoring of significant events that happened within the home. This included the absence of monitoring of falls and identifying and dealing with incidents and near misses. 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 and the service as a whole. The regional operations manager told us that systems were being implemented and as a result accident forms were being reviewed daily by a member of the senior team.

Issues around care practice had not always been identified by the provider's internal systems. We saw that new systems had been implemented to try and address issues and pick up concerns before they had an impact on people. These systems were not always effective. For example, we saw that staff were required to conduct audits of medication systems on each unit. These had not been consistently completed and the provider had not identified this. The service had undertaken full monthly and daily audits to try and address some of the medicines concerns. We were shown some audits. They audits did not identify all of the failings we found in their current practice. The interim manager and 'EMMS' manager told us that more robust audits would now take place.
We found that records did not always accurately reflect when people's health needs had changed or when they had become unwell. For example, we found that one person's care plan did not indicate that they had a pacemaker fitted. Records did not always indicate the outcome of any medical investigation. This meant that people were at risk of receiving inappropriate health and associated care. Notes about people's health were not always complete. For example, the last entry for one person recorded at the end of year was about the GP prescribing antibiotics for the signs of a UTI. The entry stated if there had been no improvement after 5 days then staff should call the GP again. This entry had not been updated in the 60 days that had elapsed. This meant that there was no record that the person's health had been monitored.

Where concerns around practice had been identified by either the provider or external agencies they had

not always been responded to in a timely or robust manner. We saw that an action plan to address issues had been completed but that not all the actions had been completed within the set time frame. We were given an explanation regarding the time frames but found that some issues had been identified as concerns in both the provider's internal audits and outside agencies some months prior to our inspection.
This meant that the provider could not be sure that systems implemented were effective and would drive improvement. We were told by the nominated individual after our inspection that they had reviewed the monitoring systems at Devonshire Court and had implemented a plan to ensure more robust monitoring going forward.
These matters, along with concerns that we found around people's health care records and systems in place to monitor people's health, constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to ensure that CQC is informed of significant events that happen in the home. We identified six occasions when we had not been made aware of safeguarding events. There had also been 11 occasions when we had not been made aware when we should have been when DoLS applications had been authorised.

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

Not all of the people that we spoke to were clear on the current management structure. One person said "I've not seen anyone – no-one has come to visit me yet to say hello." Another person told us "I've seen the manager but haven't spoken" and relative told us, "I met her early on – she's very approachable." One relative told us, "I would like there to be better communication I don't always feel staff know the situation." We were told that a residents meeting was planned to communicate to people what the management staffing structure was. There was no registered manager at the time of our inspection. The last registered manager had retired in May 2015. There had been a manager appointed in the summer of 2015 but they had left the service in February 2016. On the day of our inspection we were told that there was an acting manager in post along with an interim manager. The home was being supported by other senior managers employed by the provider.

Staff told us that they now felt supported by the management team. One carer stated "We hadn't been receiving any support from management but we do now, I can go to any of them." Another staff member said "I know their door is always open." Staff told us that the new management was approachable and that they were clear about the expectations on them within their roles. One staff member told us "We have had a lot of scrutiny from the authorities but that is good as we want to do things properly." We saw that there were regular staff meetings whereby staff were given the opportunity to fed back their concerns

Providers are required to ensure that their latest CQC inspection rating is displayed conspicuously within the home. We found that our last report which included the overall rating was displayed by the lift on the ground floor. However this was not in a conspicuous position. We discussed this with interim manager and have since received confirmation that it was now on display in the entrance to the home.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had not notified the Care Quality Commission without delay of incidents that occurred whilst services are being provided in the carrying on of regulated activities. These included notifications of injury of a service user, allegations of abuse and standard authorisations as identified in the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not ensured that care and treatment of service users was provided with the consent of the relevant people. Where a people lacked the metal capacity to make an informed decision, or give consent the service had not acted accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice in ensuring that best interest decisions had been made for people.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

The provider had not implemented systems and processes to effectively prevent abuse of service users. Where concerns had been raised the provider did not always response appropriately and without delay.

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment had not been provided in a safe way for service users. Risk to the health and safety of service users were not always assessed and action taken to mitigate risk was not always clear. Staff were not have the competence or skills to safely support people who's behaviours challenge. The provider did not have proper and safe systems in place to mage medicines.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured that records relating to the care and treatment of each person were fit for purpose, assessable to staff as necessary for them to meet the needs of people and keep them safe. The provider had not ensured that their audit and governance systems were effective.

The enforcement action we took:

Warning notice