The Royal Masonic Benevolent Institution Care Company

Cadogan Court

Inspection report

Barley Lane
Exeter
Devon
EX4 1TA

Tel: 01392251436
Website: www.rmbi.org.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced focused inspection on 12, 14 and 20 July 2017. The provider, Royal Masonic Benevolent Institution (RMBI) is part of the Masonic Charitable Foundation whose motto is 'a new charity for Freemasons, for families, for everyone' and runs 20 care services nationally. Cadogan Court in Exeter is registered to provide accommodation for up to 70 people who require nursing and personal care. The service consists of seven units over three floors known as; Holman, Barrington and Colenso-Jones, which provide care for older people who require residential care; Kneel and Osborn, which provide nursing care for older people; and Alford and Eliot, which provide care for older people living with dementia. Alford unit opened as a specialist dementia care unit in 2016. The needs of people in the home varied. Some people had complex nursing needs and remained in bed; some people had mental health needs and needed support and supervision while other people were relatively independent and needed little support. At the time we visited, 53 people lived at the service.

This focused inspection was to follow up if the required improvements had been made following our last inspection on 27 February 2017 and 2 and 7 March 2017. We had identified five breaches of regulations, related to staffing, quality monitoring, safe care and treatment, dignity and respect and person centred care. We took enforcement action in relation to the staffing and quality monitoring breaches, by serving a warning notice on the provider and registered manager. This required the provider to make urgent improvements in staffing by 14 April 2017 due to the serious and major impact on the safety and quality of services people received. They were failing in ensuring there were sufficient numbers of, competent, skilled and experienced staff to meet people's needs. We did not look at quality monitoring at this inspection because we had given the provider until October 2017 to have become compliant.

We issued requirements for the other three breaches of regulations, safe care and treatment, dignity and respect and person centred care. At this inspection we looked at the safe care and treatment and person centred care breaches. We found there had been some improvements but further work was needed to ensure people's plans fully reflected their needs and risks. We identified a new breach of regulation because some risks were not always identified or managed well. The provider took action about this during the inspection.

Since the inspection in February 2017 we have received an action plan from the provider which outlined the improvements being made. The provider is also sending a 'continuous improvement plan' (CIP) each week to the local authority and the Care Quality Commission (CQC) identifying the areas of risk and the actions they are taking to address them. The service had continued to also work in partnership with the local authority quality assurance and improvement team (QAIT) to help improve their systems and processes.

The provider had attended a local authority whole service safeguarding meeting in November 2016 because of concerns which had highlighted issues in relation to the risk management of falls, medicine management, poor practice around moving and handling, insufficient staffing levels, lack of supervision for staff and care plans not being up to date. The local authority were assured at the time by the high levels of assurances

given by the provider around how they were going to address the concerns. The meeting had decided these were more an issue of quality and so the safeguarding process was closed. This was with a view that the provider would work with the local authority QAIT and continue to improve the areas of concern.

However Cadogan Court has been the subject of a whole home multiagency safeguarding investigation since 18 April 2017. Whole service investigations are held where there are indications that care and safety failings may have caused or are likely to cause significant harm to people. The issues identified at this time related to medicine management, staffing, staff training, care plans/risk assessment, skin integrity management and people's nutritional needs being met. This has meant a suspension on further local authority placements being placed at Cadogan Court. The provider has also taken the step not to admit privately funded people to the home during this period. Following this inspection on the 25 July 2017 a local safeguarding meeting was held with the provider and it was decided that although some improvements made the home should remain in the whole service safeguarding process. This was because changes made were not embedded and therefore unable to see if effective and the provider was still working through their CIP.

We found staff levels had been maintained at the higher level put in place at the previous inspection for 90 percent of the time. The management team were actively recruiting new staff but ensuring they employed staff with the right skills to work at the home. Staff levels were above the level assessed by the dependency tool used by the provider. This meant on the whole people were getting their needs met in a timely way. However there were concerns to take in consideration the size and layout of the service and the deployment of staff to the right areas.

The skills mix and deployment of staff were not always allocated appropriately to ensure people remained safe. Poor communication within the home meant that the management team were not always aware of the day to day issues being experienced within the home.

The provider was using a high number of agency staff at the home. The manager told us at this inspection they were using approximately 40 percent of agency staff to cover gaps in the rota. Systems were put into place during our inspection to check agency staff identification when they arrived at the home. An induction for agency staff was also introduced so they knew how to support people and what to do in an emergency. Improvements had been made in relation to call bell response times. The manager was working to improve these further.

Risks to people's safety on Alford Unit both for people living there and the staff working on the unit were not well managed or documented. Two people had regular altercations which was seen as part of their normal pattern of behaviour. One had the habit of going into other people's rooms. There was a lack of guidance as to how staff should prevent this happening.

Care plans contained personalised information including people's social history and morning, afternoon and evening summaries of care. However, some of the information was not up to date and did not provide clear advice to staff how to manage people's care needs. The management team were revising everybody's care plans as part of their continuous improvement plan (CIP) and had completed nearly half at the time of the inspection. The provider said this was taking time because staff were being trained to complete the care plans as part of the process and they were being completed thoroughly. They said they planned to have them all completed by the end of October 2017 and were prioritising them dependent on the level of risk.

People had 'wardrobe care plans' in their rooms. Handover sheets were available to staff but did not always contain people's relevant information to guide agency and staff new to the home. Improvements were made

to the information on the handover sheet during the inspection. Improvements were made during the inspection regarding people's individual risks in relation to fluids, nutrition and continence. This meant staff would have the right information to provide effective care and support.

The service had a registered manager who we were informed by the provider was on extended leave for three months from the 20 June 2017 and was not working at the home. An interim manager was in place at the time of our inspection. Following the inspection the provider informed us that the registered manager had resigned their position as the registered manager and the interim manager had been appointed. They would be submitting their application to CQC to register as the 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.

Since the last inspection a clinical lead had been appointed into a new position. The provider had also sought the input of a consultant who is referred to at the service as the support manager. The role of deputy manager was vacant and the provider was actively looking to recruit to this position. The manager was also supported by the provider's regional operations manager who visited the service every week along with senior management staff who specialise in medicines, pharmacy and compliance and audits. The manager put in place a temporary staff organisation structure guide during our visit so staff were clear about the roles and responsibilities of the management team and who they should approach. The clinical lead and support manager work at the service seven days a week and are visible on the wings. They were working with the care staff to raise their awareness of issues found. The manager said they would like to be out and about more but were prioritising the areas which needed to be addressed but planned to increase their presence once things settled down.

There was a positive culture at the home staff fed back that they were seeing improvements and were aware of what was being done. They all said they "weren't there yet but were making progress" and felt people were being cared for safely. Staff were positive about being able to approach the new management team and said they felt they were listened to. One care worker said, "Teamwork has got better" and that the management team were now more approachable. The management team were trying to build up staff morale. They had arranged a team building event which took place between our first two visits, staff were positive about the event. The service already had employee of the month and the manager said they wanted to strengthen that and have spur of the moment recognitions of staff performances for example an "awesome award."

The manager said they had an open door policy and some staff had approached them to have a chat. They had held a full staff meeting where staff were informed about what was happening and were able to make their views known.

People said they had seen improvements and were positive about the experience of living at Cadogan Court. They said, "feel safe because all the staff are so lovely and friendly"; "It's just the place itself that makes me feel safe"; "They always make sure I have my call bell on hand"; "It's so homely here, it makes you feel so comfortable" and "You feel you have come to somewhere you can relax."

People received their medicines safely and on time and significant improvements had been made in the safety of medicines management.

The provider had purchased new equipment so it was easily available on each unit when needed.

There were positive interactions between people living at the home and staff. Staff checked on people's well-being and encouraged people to drink. People's personal preferences were being respected by staff who were committed to working in a person centred way. However where one person with limited capacity was resistant to receiving support which would maintain their dignity, staff were leaving them for long periods of time. There was no system to monitor how long it took before successful intervention were undertaken to ensure these people were not at risk of being neglected.

The activity provision at the home had improved. There was activity staff cover every day which helped meet the needs of people who needed additional support. Staff used their knowledge of people's personal history to engage with them. There were regular communal events as well as provision for individual to undertake things meaningful to them.

Two ongoing breaches of regulations were identified at this inspection. These were in relation to staffing, person centred care. We also identified a new breach in relation to management of risk We are taking further action against this provider and will report on this when it is completed. We will carry out a further inspection within the next six months to check all the remaining requirements have been met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

The provider were using a high level of agency staff to ensure there were adequate staff to meet people's needs.

Improvements were put into pace to ensure agency staff had the information they required to meet people's needs and keep them safe.

The skills mix and deployment of staff were not always allocated appropriately to ensure people remained safe.

Risks to people were not always being safely managed.

Medicines were managed safely at the home. People received their medicines when they needed them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Information in care records was not always up to date and did not provide clear advice to staff how to manage people's care needs. The management team were revising everybody's care plans.

Handover sheets were available to staff but did not always contain people's relevant information. Improvements were made to the information on the handover sheet during the inspection

People were supported to take part in social activities. Improvements had been put into place to ensure people were not at risk of social isolation.

Cadogan Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12, 14 and 20 July 2017. The first day of the inspection was unannounced and carried out by two adult social care inspectors, a pharmacist, a specialist advisor who was a registered nurse and two experts by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service. We announced the second and third day of our visit so we could speak with the manager. On these days only the two adult social care inspectors visited.

Cadogan Court in Exeter is registered to provide accommodation for up to 70 people who require nursing and personal care. At the time we visited, 53 people lived at the home.

Prior to the inspection we reviewed information we held on our systems. This included reviewing whether any statutory notifications had been submitted to us. A notification is information about important events which the service is required to tell us about by law. We identified the last notification we received from the service was 6 April 2017 until we were informed about the absence of the registered manager on 28 June 2017. We discussed this with the manager who was able to show us the paper copies of notifications which had been completed during this time and we were unable to establish why CQC did not have a record of them. The manager has since submitted two notifications which CQC have received. Therefore it is not clear why CQC have not received them.

We met the majority of people who lived at the service and received feedback from 13 people who were able to tell us about their experiences. A few people using the service were unable to provide detailed feedback about their experience of life at the home. We spent time in communal areas observing the staff interactions with people and the care and support delivered to them. We used the Short Observational Framework for Inspection (SOFI) in the Alford unit. SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We also spoke with three visitors to ask their views about the service.

We spoke and sought feedback from 14 staff and others during the inspection. These included the new manager, support manager, clinical lead, nurses, shift leaders, care workers, medicine champion, administrators, operations coordinator and housekeeping staff. We also spoke with the provider's regional operations manager and a deputy manager from the provider's other home who was at this service working with staff in regards to medicine management.

We reviewed information about people's care and how the service was managed. These included eight people's care records along with other records relating to the management of the service. This included staff rotas, the provider's 'continuous improvement plan', call bell logs, notification file and medicine audits. We also looked at 21 people's medicine records and the systems in place for managing medicines, and we checked how they were administered to people. We spoke to staff involved in managing and administering medicines, and watched some medicines being given to people.

As part of the local authority whole service safeguarding process we have spoken with the local authority safeguarding adults team manager, responsible manager for commissioning and two members of the quality assurance and improvement team.

Inadequate

Is the service safe?

Our findings

At the previous inspection in February 2017 we took enforcement action by serving a warning notice because of the staffing levels found at the home on the first day of our visit. We found people were not having their needs met safely by adequate staffing levels. We raised this with the registered manager who had taken immediate action and increased the staff levels. Previously there was a nurse and shift leader and 14 care staff in the morning and 12 in the afternoon and six at night. The new staffing levels was the nurse, shift leader and 18 care staff throughout the day and seven care staff at night. They were also supported by the senior shift leader who worked through the day. However they were absent during our inspection.

At this inspection the staff levels had been maintained at the higher level. The support manager said they had been able to maintain the higher staff level for 90% of the time. The manager explained that there had been a 60 percent turnover of staff in the last year which they were working to improve by supporting staff and increasing staff morale. They said they were actively recruiting new staff but this was taking time owing to the low amount of applicants and also ensuring they employed staff with the right skills to work at the home.

People said they had seen improvements in the staffing levels and were positive about the experience of living at Cadogan Court. However one person said, "I sometimes feel that there's not enough carers." However others said staff were "very kind and helpful", "good" and "excellent". Other people were also positive, for example saying "It's the staff, they make me feel safe"; "People are always coming in to see how I am" and "very well looked after" and appeared relaxed in their interactions with staff. A relative said, "There's always somebody popping in to check on mum." Staff said they would like to have their own team but they said on the whole they had had consistent agency staff. Staff were positive about working at the home, for example saying, "I love it here."

The provider was using a high number of agency staff at the home. The manager told us at this inspection they were using approximately 40 percent of agency staff to cover gaps in the rota. They said they used three main agencies but at times had needed to use two others when they were unable to find a staff member to complete a shift.

On the first day of our visit there were no systems in place to check agency staff identification when they arrived at the home. There was no induction for agency staff to ensure they had the information at hand which they required to support people and know about emergency procedures at the home. There was a new induction checklist that had recently been introduced across the organisation and this was being implemented at the time of inspection. The manager took immediate actions following our feedback. This was to ensure agency staff identities were checked, inductions took place and this process was being monitored. The manager had met with the agency managers to discuss the need for consistent staff. They were also working with their team to produce staff rotas for four to six weeks in advance so planned agency booking arrangements could be made. The provider wherever possible had tried to ensure they used consistent agency staff. This was so the agency staff knew the people they were working with and were familiar with the service. The provider wrote to us after the inspection to make us aware that recent

meetings had been held to agree extended contracts with the agencies. They said this was so they can secure the best agency staff for up to six months at a time while recruitment is ongoing.

Handover information did not always contain important and vital information about each person and how to keep them safe. For example on one unit significant risks to people's safety had been omitted. The information missing included one person being visually impaired and another person being at very high risk of falls. On the Osborn unit the handover sheet contained only the list of the people on the unit, and did not cover their needs and risks. People had 'wardrobe care plans' in their rooms which contained more detail. The management team took action after the first day and put in place more detailed handover sheets.

The provider used a dependency tool and had identified people's needs had increased at the home. To ensure staffing levels were safe, the manager had completed the dependency tool to assess people's needs to ensure every aspect of their care and support was covered. They confirmed the staff levels at the home were above the amount of hours required. The layout of the home has seven different units which adds to the availability of staff in the right areas and is a key factor in the staff requirements. They were looking at this.

The skills mix and deployment of staff impacted on the experience of people living at the home. For example, on our first day on Alford, one of the units for people living with dementia, we met three agency staff members who said they had not worked on the unit before or had not worked on the unit for several weeks. These staff were providing care and support with people who had behaviours which were challenging. For example, two people on the unit found assistance with their personal care and incontinence distressing. Staff who was unfamiliar to one of them being given the task to assist them. An agency staff member quietly advised another agency staff that the person could bite and kick staff. Neither had worked on the unit before.

We talked with the permanent staff on the unit; one person described how they were a new team and were only beginning to "find their voice". They said they had requested more continuity for agency staff but felt this was only recently being listened to by staff allocating agency cover. Staff records showed that six of the permanent day staff team for Alford had been in post less than ten months. The management team told us they recognised that for people living with dementia it was important to provide staff who knew how to support them in a way which minimised their distress. They told us at our feedback meeting at the end of the inspection they were addressing this issue and were implementing a system so they could match agency staff to units they had worked on before. They were also introducing a block booking agreement with agencies to help with consistency and the deployment of staff. After the inspection the manager said they were prioritising that consistent staff were deployed on the two dementia units. This was so staff would have a good understanding of people's needs and be able to support them appropriately.

We met a permanent staff member who had only worked on the unit once before. They told us they had attended a verbal handover before their shift began but three said they had not received written information about the people they were caring for. We saw new staff to the unit checking with permanent staff how to support people. For example, checking if they were diabetic, how to intervene when a person was only wearing one shoe, how to encourage a person to eat. This was only effective when permanent staff were available to ask.

We discussed this with the management team and asked why they were not aware of the difficulties being faced on the Alford unit. The manager said they had a daily meeting with the management team which included the shift leaders to ascertain what was happening in the units. Following the inspection we were told by the manager that improvements had been put into place to ensure the shift leader had a clearer

oversight of the dementia units. We asked how staff contacted the shift leader who was responsible for five of the units if they required support. The manager said in an emergency, staff would use the emergency call bell which sounded across the whole service. They could also telephone for assistance and the manager assured us they would ensure staff had the contact numbers. They also put an extra staff member on the Alford unit straight away to ensure there were enough staff to meet people's needs on the unit.

Whilst there were now sufficient numbers of staff the deployment of staff was not being effectively managed. Staff did not always have the right knowledge and support to care for the people they were providing care for.

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

There had been improvements made in relation to the staff sickness levels at the home. The management team undertook return to work interviews with staff to support them back into work. Staff morale had increased and the manager had spoken with staff at their first staff meetings and made it very clear about what was expected about behaviour and absence policy and sickness. Staff said recent changes of management were having a positive impact on the atmosphere and staff morale at the home. The management team were trying to build up staff morale. They had arranged a team building event which took place between our first two visits, staff were positive about the event. They already had employee of the month and the manager said they wanted to strengthen that and have spur of the moment recognitions of staff performances for example, "an awesome award."

Call bells at the home were set to go to a sustained emergency ring after six minutes. We discussed with the management team on the first day that staff on one unit had not responded to a call bell. The manager said they would remind staff of the need to respond to bells on their own unit. During our visits we did hear the emergency bell a few times but these were answered more promptly. We requested some random call bell logs. We were sent ten call bell logs for different shifts. We identified that the early shift was where there had been more emergency calls which had activated after six minutes and the night shifts where there were a lot less. On one occasion during one shift, the emergency call bell had activated after six minutes a total of 16 times and another shift, eleven. The manager was speaking with the management team and staff about improving response times further at the daily meetings.

At the previous inspection staff had needed to leave the unit they were working on to get equipment or to find an additional member of staff to assist them. Additional equipment had been purchased by the provider so staff had equipment they required on each unit. Mobility aids and wheelchairs were evident for people to use during our visits. With the increase in staff levels there were two staff on each unit so staff did not need to leave their unit to find a second member of staff to assist. This had a positive impact on people having their care needs met and having a staff present to monitor their safety.

Risks to people's safety on Alford Unit both for people living there and the staff working on the unit were not well managed or documented. A staff member commented that the two people were in regular altercations and it was seen as part of their normal pattern of behaviour. One had the habit of going into other people's rooms. This action was identified in their 'wardrobe care plan', which said 'constantly mobile and searching, entering other residents' rooms, resulting in confrontation.' Records showed this was not a new behaviour. We made a staff member aware that the person was in the wrong room but they did not intervene. Some staff were more proactive than others in the way they interacted with this person. Steps were not taken to monitor the person's location and bedrooms that were not occupied had their doors left open. There was a lack of guidance as to how staff should prevent this happening. This meant the person was left to wander

into rooms which could cause further altercations.

Behavioural charts were used to help staff document people's behaviours, log what had happened and the outcome. The purpose of the charts was to consider possible triggers and to review, for patterns of behaviour to help provide care in a way which was less likely to result in an incident. A staff member said it was unclear what the trigger was for one person but we saw most incidents were linked to personal care. Some charts had been completed inaccurately. We requested the behavioural charts for two people, these were amongst other people's records and had not been filed, they were difficult for staff to find and there were some weeks that were missing. These examples showed there was an ineffective system of assessing the risks to people and staff. The clinical lead said they planned to spend more time on the units for people living with dementia to help provide a greater oversight on the care provided and be a positive lead role.

Staff used a nutritional risk assessment tool to ascertain if people were being assessed appropriately. The support manager had been working with staff regarding accurately completing this assessment tool. They had also completed an audit of the past three months of people's weights to ascertain if anyone was at risk. However one person's assessment recorded showed they had lost weight but no action had been taken regarding this in the person's care plans. We discussed this with the support manager and identified the person had not lost weight but the data had been added incorrectly. Action was taken during the inspection to amend this. Where people had been found to have lost weight and the protocol had identified that they required weekly weights it was not clear this was happening. There was no clear guide as to how it was decided what quantity of fluids a person should have. There were numerous fluid monitoring charts in use but these were not collated to assess how much people had drunk to ensure they had received enough. On the second day new systems had been put in place to address these concerns.

A person was assessed as being at high risk of falling. When we arrived on the unit, the person was walking with a frame with one shoe on which was on the wrong foot. A new staff member queried how to encourage them to put on their shoes correctly but was told to wait until the right moment. This was not rectified until two hours later.

The system used to monitor if people have had their bowels open was not effective as it was not clear who was recording the information and what actions were needed for individuals. On the second day of our visit a new monitoring chart was put in place with guidance of who was responsible for filling in the chart and what actions needed to be taken. Staff were also reminded to refer to people's individual care plans to guide them of their individual need.

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

The home remained clean and free from offensive odours and domestic staff no longer took on the role of maintaining tidying and bed making in people's rooms. This had been passed back to the care team. We did not identify any beds that had not been made or rooms in an untidy state without the bins being emptied.

Medicines were being safely managed at the home. There had been improvements made to the way medicines were managed in the home since our previous inspection. New systems, audits and documentation had been introduced, and more staff time had been made available through the creation of a new post of 'medicines champion'. This meant there was more staff time for ordering, and managing medicines and ensuring audits and incident monitoring was effective.

We observed medicines being given to people and saw that these were given using a safe

method. People were asked if they needed any medicines that had been prescribed for them on a 'when required' basis, for example pain relief. One relative said, "The nursing care is very good, they are in fine tune with my mums medicines.

Medicines were stored in individual cupboards in people's rooms and these have been updated to ensure they were suitable for holding enough supplies. Other medicines were stored securely, and there were suitable arrangements for managing medicines needing cold storage and those needing extra security. There were suitable systems and records in place for the destruction of unwanted medicines.

Staff completed medicines administration record (MAR) charts when medicines were given to people. These were usually printed by the supplying pharmacy but if handwritten amendments or additions were needed, these were checked by two members of staff to ensure that the details were correct. The MAR charts were completed when medicines were given, or reasons recorded if any regularly prescribed medicines were not given. New and updated protocols for any medicines prescribed 'when required' were available and separate charts to record the time and reasons for these medicines if they were given. Risk assessments were in place for any higher risk medicines for example strong pain killers, or medicines which needed monitoring. There were separate charts for recording the application of creams and other external preparations. These contained body maps and clear directions for staff as to how these preparations should be used.

Medicines round times had been changed since our previous inspection to make sure medicines that were needed before food or early in the day were given at suitable times. The remaining morning medicines were given at a separate round a little later. However we saw that this round took longer. For some people who were prescribed pain relief every four hours, there was a risk that the lunchtime dose may be due too soon to be given safely. For people prescribed pain relief regularly the time of administration was not recorded, leading to a risk that doses could be given too close together. For example, one person requested a further pain relief medicine at lunchtime but staff had not recorded the time the dose had been given in the morning. This meant that it could not be administered straight away, until staff could be sure there had been a safe time gap between doses. We discussed this with the management team at the end of our first day and they said they would look at ways to make sure this was addressed to ensure all medicines were given at suitable times. On the second day of our inspection improvements had been made to ensure people received their pain relief at intervals as prescribed.

There was a medicines policy available to guide staff and new monthly and weekly medicines audits were completed for each unit. These picked up issues and recorded how these had been addressed. Errors or incidents involving medicines were reported and investigated, and the number of these incidents has dropped since improved systems had been introduced. Updated training for staff who give medicines had taken place. This was followed by staff competency checks to make sure that they administered medicines safely.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection people were not receiving care that was responsive to their needs and personalised to their wishes and preferences. People could not choose to participate in organised activities and were supported to organise their own activities if they wanted to due to staff levels. At this inspection there had been improvements but more needed to be done to ensure the service was fully responsive to people's social and emotional needs.

People had a care plan which was discretely and securely stored in their bedroom. These contained a large amount of personalised information including people's social history. Care plans followed a comprehensive format with an extensive index including morning, afternoon and evening summaries of care, supporting relationships, strengths and abilities to maintain and improve and life history. A new monthly review check list had been put into place to review people's care records. However, some of the information was not up to date and did not provide clear advice to staff how to manage people's care needs. As part of the continuous improvement plan (CIP) staff were working with the clinical lead and support manager to revise people's care plans and put into the new format. They had completed nearly half of these at the time of the inspection. The care plans were paper based but the manager said there were discussions about going onto a computerised system.

We looked through four people's care files with the management team and highlighted areas that required reviewing and updating. For example, during our time on Alford, we saw one person urinate on the floor; they were distressed. Records showed incontinence was a significant issue for this person and impacted on their behaviour towards staff. We reviewed the incidents where they had been aggressive towards staff and the majority were linked to requiring staff support after an episode of incontinence. The staff were not working with the person to develop a toileting regime which might prevent them becoming incontinent. The person's care plan did not reflect the impact of their incontinence and did not outline how staff could alleviate the person's distress. This area of their care had not been meaningfully reviewed to consider how to manage their incontinence more effectively.

One person had an area of skin which had not healed. Staff were finding it difficult to treat the area as the person was reluctant for them to intervene. We could not establish what treatment had been provided and if the area was healing. There was not a specific care plan instead their general care plan said 'at present my skin is intact and fine' which had not been updated. Community nurses were visiting but information was not available to describe their input. The new manager said they would address this.

Staff said that one person living with dementia would only receive support from staff on their own terms; they advised new staff to the unit to follow this approach. The person chose when they ate and where. However on one occasion it was forty minutes after the meal had been served they chose to eat their cooked meal which had not been kept warm. This meant that staff were not providing responsive care to this person.

Incident records showed there were times when staff were unable to persuade the person to accept

personal care leaving them in soiled and wet clothing. Daily records showed this was then provided at a later time when the person was calmer. We recognised staff were committed to working in a person centred way but we were concerned records were not reviewed to monitor how long it took before a successful intervention was achieved.
We talked with staff about how pain was monitored for two people living with dementia. Both people's care records showed there were regular occasions when they were unsettled. Staff told us and records confirmed that one person was reluctant to take their medicine and most had been stopped by the GP. We saw they were still prescribed pain relief but did not take it and a body map showed where they regularly experienced pain. However, a best interest meeting had not taken place to decide how their pain could be managed if they continued not to take pain relief. We raised this issue on the first day of our inspection and a GP visited on the second day of our inspection. The management team said a review would take place to decide how the person's care needs could be met.

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

We saw people's personal preferences being respected by staff as to when they got dressed and got up. For example, staff knew people's personal preferences, such as when they got up and breakfast was served at different times to reflect people's choices. People said, "I can get up and go to bed whenever I want, they leave it up to me"; "It's like a holiday camp"; "I can have a bath at my choice of time and day"; "The staff do everything for me, I love them"; "The staff are very helpful" and "The staff don't stop you doing anything."

A staff member described the keyworker system and their role as some people's named keyworker. They said the keyworker system had slipped a bit with staff changes, but they told us their attitude was to "look out for all of them."

Staff were quick to respond to people's changing moods. For example, when one person was distressed, an agency staff member softly read to them, the person snuggled into them and relaxed for a period. One person's care plan stated that they responded well to staff talking about events from their past and we saw staff adopting this approach. Another person had minimal engagement with staff because of long periods of walking around the unit but staff acknowledged them when they saw them.

There were positive interactions between people living at the home and staff. Staff checked on people's well-being and encouraged people to drink, checking what they would like and making it accessible for them. On Alford unit, staff worked in a person centred way, adapting their approach to respond to people's interpretation of their surroundings. For example, one person was reluctant to have a drink as they said they did not have money to pay for it. The staff member said "You've paid me, my friend. All included." The person then happily took the drink from them. Staff encouraged people to drink and ensured drinks were in reach, although some staff were more proactive in encouraging people to drink than others. For example, one person walked a great deal and two staff members offered them a sip from their preferred drink each time they walked past as they understood the person did not wish to sit down. On the second day, we did not see them being offered a drink as regularly.

The management team said they had a dementia specialist who was looking at the dementia care at the home and the training needed. The manager had a mental health background and said they would also be looking at how care was delivered to people on the Alford unit. They were reviewing the number of people who used the lounge area on Alford to ensure people did not feel overwhelmed by too many people. They also wanted to ensure people living with dementia had access to other communal areas in the home to provide greater variety.

On both days of our inspection, a second person held one side of their head and looked in pain. A staff member asked the person what was the matter and did they have a headache. The person confirmed they did, saying "It hurts" and "It's terrible." The staff member checked with another staff member who confirmed the person had been prescribed pain relief which was given via a patch. We shared our observations with the management in our feedback at the end of the first day. We asked them to report back on if the person's current pain management was effective and if a health professional had reviewed the person's medicines.

Since the last inspection, the number of activities staff had increased with a third staff member appointed during the inspection. Staff in this role said there was a plan to meet with the new manager to discuss how everyone's social needs could be met, including those who chose to stay in their room. Activities staff had attended internal training at another home, which they found a useful event. Their hours meant there was cover for every day with an overlap on one day per week. Staff said this helped meet the needs of people who needed additional support; they said the additional third member of staff would also help provide extra support for people. They said care staff rarely attended social events which sometimes made it difficult to meet everyone's needs, including those with a sensory loss.

Staff used their knowledge of people's personal history to engage with them. For example, discussing the names of tools or previous holiday destinations. Staff were inclusive in their conversations so people living at the home were involved, for example supporting a person to complete a crossword, which was their preferred hobby, with the help of other staff members. The atmosphere was calm and people looked relaxed as people were supported to be engaged in a craft activity or discuss the plants on the balcony.

Other people were observed in their rooms, watching television, reading or doing crossword puzzles.They said this was their choice. Comments included, "There's not much to do, but I don't mind"; "I like to sit in my room and have some peace and quiet"; "The home recently arranged a taxi for me to take me for a hospital appointment" and "I like to sit in my room and read or do a crossword." A relative said "I regularly take my relative out to the garden centre."

There was not a set budget for activities which staff said this could be difficult as it made planning external events difficult. However, they said friends of the service were generous in providing funds for a specific purpose.

A monthly newsletter of events and photographs were given to people. Activity records for July 2017 showed there were a good range of communal events in the main lounge, such as a history quiz, crafts, scrabble, bingo, listening to 50's music, indoor bowls, watching tennis, chair exercises, external entertainers and films. These were well attended and staff recognised friendships and different abilities. A weekly hairdressing service visits the home and religious services are held. One person said how they were supported to visit their spouse, which we saw from records and photos. Staff knew their favourite song and said they requested external musicians to play it for them. Activity records for people cared for in their rooms showed the activities staff visited them, including with the mobile shop. People had the opportunity to visit local shops and attractions as staff had access to a minibus and car. People who were more able were using the reception area for reading newspapers and chatting.

On the Elliot unit the main communal room was set up as a pub, with one corner set up as a garden shed. The manager said the men used this area and he wanted the area to be used more regularly. There was a train compartment in the corridor on Alford, with two seats and a moving 'view' which could be projected on the 'window', which could be used to engage people.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured people received care and treatment which was appropriate and met their needs. Reg 9(1)(a)(b)(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken practical steps to assess and mitigate risks to people. Reg 12 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff with the appropriate skills and induction were deployed appropriately to meet people's needs. Reg 18 (2)