The Royal Masonic Benevolent Institution Care Company

Cadogan Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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 were cared for 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, 51 people lived at the service.

There was a manager employed at the home, although they had not yet registered with the Care Quality Commission to manage the service.

The last comprehensive inspection of the service was carried out on 27 February 2017 and 02 and 07 March 2017. At that inspection we 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 and to improve quality monitoring processes by 09 October 2017, due to the serious and major impact on the safety and quality of services people received. They were failing to ensure there were sufficient numbers of, competent, skilled and experienced staff to meet people's needs. We issued requirements for the other three breaches of regulations, safe care and treatment, dignity and respect and person centred care. The overall rating for the service at that inspection was 'Inadequate' and the service was therefore placed in 'special measures'. Services in special measures are kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Staffing levels were increased during this inspection in response to the concerns raised. Following the inspection the provider sent us an action plan, outlining the improvements being made and a weekly

'continuous improvement plan' (CIP) to the local authority and the Care Quality Commission, identifying the areas of risk and the actions they were taking to address them.
The service continued to work in partnership with the local authority quality assurance and improvement team (QAIT) to help improve their systems and processes.

We carried out an unannounced focused inspection on 12, 14 and 20 July 2017 to check that the required improvements had been made following the comprehensive inspection in February and March 2017. At this inspection we looked at the breaches of regulation related to safe care and treatment and person centred care. The higher staffing levels put in place at the previous inspection were being maintained for 90 percent of the time. However, 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. Action was taken during the inspection regarding these concerns. Following the inspection we wrote to the provider to formally request information about the actions they had taken to minimise the specific risks we had identified. They sent us the information we requested, detailing the actions they were taking.

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 concerns about medicine management, staffing levels, staff training, care plans/risk assessment, skin integrity management and people's nutritional needs. These concerns had meant the local authority placed a suspension on any further local authority placements at Cadogan Court. The provider had also voluntarily agreed not to admit privately funded people to the home during this period.

A local authority safeguarding meeting was held with the provider on 14 November 2017 and it was decided that although some improvements had been made, the home should remain in the whole service safeguarding process. This was because the changes made were not fully embedded and the provider was still working through their CIP.

At this inspection in October 2017 we found people continued to be at risk because the service continued to be poorly led. While the provider had identified where improvements were needed, people were not protected by the provider's systems and processes to monitor the safety and quality of their service.

Staff were not always available to meet people's needs and keep them safe. There were five occasions during the inspection when no staff were present in the communal area of Alford unit to support people who had been assessed as being at risk due to falls, choking or behaviour that challenges. Two staff had not arrived for work on the two nursing wings when we visited at the weekend, which meant there were five staff working there instead of seven. The skills mix and deployment of staff undermined their ability to take the actions required to understand and minimise risks. New staff were moved around the different units during their induction, which they told us made it difficult for them to become familiar with people and their needs, or to support them in line with their individual preferences. An agency member of staff was left to cover Alford unit on their own on their first shift there, so other staff could have a break. People told us staff were too busy to spend time with them. Staff confirmed that although they were able to meet people's basic needs, they were rushed. One person had to remain in their room until there were enough staff available to provide the one to one support they needed in the communal area.

The provider confirmed that staffing was a concern at the service, with 50 per cent of the workforce being agency staff. Recruitment was their 'biggest priority'. They responded immediately to our concerns by increasing staffing levels on the dementia units and booking an agency registered mental nurse (RMN) to work there for a minimum of two months for consistency. A new two week rolling rota was being

introduced the week after the inspection, which would ensure better coverage of all units by permanent staff who knew people's needs. The manager was working with agencies to develop a consistent core team of staff to work at the service. Three weeks after the inspection the provider informed us the number of agency staff had reduced to 44 per cent.

People and relatives spoke very positively about the quality of the support they received from some permanent members of staff. However, there was a risk they would not receive effective care because staff did not always have the competence, skills and experience to provide it. Although there was a comprehensive induction and training programme in place, this did not always enable new staff to safely meet people's individual needs because they did not have the time and support they needed to complete it. One new member of staff told us, "There is no support for the people who have just started." In addition staff did not consistently receive supervision and support in line with the provider's policy. There was an induction for agency staff, but feedback received during the inspection suggested this was not always effective in enabling them to support people safely. Information about the training, skills and knowledge of agency staff had not consistently been requested from the agencies, which meant the provider did not know whether they had the skills and knowledge to support people safely.

Staff did not consistently follow safeguarding policies and procedures, which meant people were not always protected from the risk of abuse and avoidable harm. Following the inspection the provider advised us that the safeguarding policy had been re-issued to staff and was under review.

Since the focussed inspection in July 2017 all care plans and risk assessments had been reviewed and risk assessments had been completed in relation to people's skin, diet and mobility. When risks had been identified, we saw plans were in place to manage and reduce these risks where possible. Care plans had been updated since the last inspection and many now contained good person centred information for staff to follow, but this was not consistent. Care plans did not document people's end of life wishes or provide the information staff needed to support them according to their wishes and preferences. Some care plans were not reflective of people's current care needs. They did not always provide the guidance staff needed to support people safely and effectively in line with their preferences. People and their relatives had not always been involved in drawing care plans up and their review. The provider's representative acted immediately to address our concerns about the care plans. They told us they were introducing a 'resident of the day' initiative. This which would help to ensure care plans were reviewed regularly with people and their representatives, so staff had a better understanding of people's needs.

People told us they were able to make decisions about how they wanted to be cared for, including where they spent their time, what they wore and where they ate. We observed that staff showed concern for people's well-being in a meaningful way, and supported them with patience and kindness. People told us most staff were caring and compassionate. However, staff did not ensure people's privacy and dignity was maintained at all times. For example, on five occasions when we were talking to people in their rooms members of staff walked in without knocking and without saying 'excuse me'. We raised this with the provider's representative, who gave reassurances this would be addressed with staff.

People lived in an environment which had been assessed to ensure it was safe. Personal emergency evacuation plans were in place (PEEPs) so that they would receive the support they needed in an emergency.

Staff were recruited carefully and appropriate checks had been completed to ensure they were safe to work with vulnerable people.

People told us they received their medicines when required. Medicines were managed and stored safely.

People chose to eat in the dining room or in their room if they wished. They spoke very positively about the quality of the food and choices available. People had sufficient to eat and drink and received a balanced diet, and care plans guided staff to provide the support they needed.

People's health needs were monitored and action taken to address any concerns or changes. Records showed they had been referred to external health and social care professionals as required. The service was working with the GP practice to improve the communication systems used to document visits and guidance given by health professionals.

People's human rights were protected. When someone did not have the mental capacity to make certain decisions, care records showed that decisions had been made according to their best interests.

The service was working to improve the quality and safety of care provided to people at the service who were living with dementia. Observations had been carried out of staff practice on the units, and people's responses to it. There had been training to enable staff to safely prevent a person causing harm to themselves or others. Further training and monthly reviews were planned with the provider's dementia specialist.

The home had an activities programme run by three activities co-ordinators, and people were supported and encouraged to participate and to socialise. There were scheduled 'one to one' sessions for people who were cared for in their rooms.

The manager told us they were working to change the 'negative' culture of the service and were working to build a more open and transparent culture. They wanted to build a strong staff team and for staff to feel valued. The provider and manager demonstrated an open and transparent approach throughout our inspection. For example, showing us what they had identified themselves as already requiring improvement and taking immediate action to address the concerns raised. This demonstrated their understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. The provider had displayed their latest rating in line with legislation.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Although risks to people's safety had been assessed and preventative actions taken to reduce the risks of them experiencing harm, staff were not always available to ensure people remained safe and receive individualised care in a timely way.

The skill mix and deployment of staff meant that people were at risk of not receiving safe care.

People were not protected from abuse because staff did not know what action to take if they were concerned about a person's wellbeing.

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

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive the training and support they needed to provide effective and safe care to people.

The provider did not always obtain the information they needed to judge whether agency staff had the skills and knowledge to support people effectively.

People's rights were protected by staff who understood their legal obligations, including how to support people who could not consent to their own care and treatment.

People had a choice of appetising and nutritious food and drink, which they could eat in the dining room or in their room if they preferred.

People had access to external health and social care professionals to maintain their health and wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff supported people with patience and kindness, however they did not ensure people's privacy and dignity was maintained at all times.

End of life care planning was lacking and did not ensure people's needs were known and met.

Staff, were kind, caring and compassionate and worked hard to understand and meet people's basic needs despite the lack of staff.

People and their relatives, where required, were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Information in care records was not always accurate and did not always provide clear guidance to staff about how to manage people's care needs.

There was a complaints policy and process in place, but relatives were not always satisfied with the way the service responded to their complaints.

A care plan summary was given to staff to inform them about people's needs and how to support them.

People were able to take part in a range of social activities.

Is the service well-led?

Inadequate

The service was not well led.

While the provider had identified where improvements were needed, people were not protected by the provider's systems and processes to monitor the safety and quality of their service.

There was a manager in post who was not registered with the Care Quality Commission to manage the service.

The majority of staff had confidence in the manager and felt there had been some positive changes at the service.

The provider and manager were committed to making the improvements	

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 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.

This inspection took place on 16, 17, 22, 25, 30 October 2017, and was unannounced on the first and third days. The inspection team consisted of two adult social care inspectors; a specialist advisor with expertise in nursing and dementia care and two experts 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. On the first two days the adult social care inspectors were accompanied by the CQC's senior equality and human rights officer, who was there to observe the inspection process.

Prior to the inspection we reviewed information we held about the service, including notifications, previous inspection reports, safeguarding and quality assurance reports, feedback from Devon County Council commissioners and community health professionals. A notification is information about specific events, which the service is required to send us by law.

We looked at a range of records related to the running of the service. These included staff rotas, four supervision and training records, 22 medicine records, meeting records, quality monitoring audits and the service's continuous improvement plan. (CIP). We also looked at 18 care records and the summary care plans for all the people living at Cadogan Court.

Some people living with dementia were not always able to comment directly on their experiences. We therefore 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 spoke with 16 people and 10 visitors to ask their views about the service. We spoke with 44 staff. This

included nine agency staff, kitchen and domestic staff, the training officer, the manager, deputy manager, regional manager, RMBI pharmacy and dementia specialist lead and the RMBI assistant director for compliance and audit. We also spoke with two health and social care professionals who supported people at Cadogan Court to obtain their views about the service.

Inadequate

Our findings

At the inspection in February 2017 there were significant concerns about people's safety. There were not enough staff to respond to people and manage risks, and people's medicines were not managed or administered safely. We found two breaches of regulations related to staffing, and safe care and treatment, and the service was rated 'inadequate' in this domain. We took enforcement action by serving a warning notice around staffing levels.

At the focussed inspection in July 2017 there remained significant concerns about people's safety. Risk assessments, did not always provide the information and guidance staff needed to understand and minimise risks, particularly when people had behaviours that were challenging. Whilst in July 2017 there were sufficient numbers of staff, including a high number of agency staff, their deployment were not being effectively managed. This meant there was a lack of consistency and continuity, and people were frequently supported by staff who were unfamiliar to them. Staff did not always have the right knowledge and support to provide safe care to people. We found a breach of the regulation related to safe care and treatment and a repeated breach of the regulation related to staffing. The service was again rated inadequate in this key question. We issued two requirement notices. We also wrote to the provider to request information about the action they intended to take to address these concerns and received a satisfactory response.

At this inspection in October 2017 we looked to see whether improvements had been made and found people were still at risk because staff were not always available to meet their needs and keep them safe. The provider advised that staffing levels were in excess of the requirements calculated using their dependency tool. Alford and Elliot units, where people were living with dementia, were each staffed by two care workers, with a 'floater' (a care worker covering both units). However, on Alford unit where people were living with dementia, there were five occasions during the inspection when no staff were present in the communal area. A relative told us this was often the case when they visited. On three of these occasions one person was sitting at the table with food. The person had been assessed by the speech and language team (SALT) and prescribed a soft diet due to their risk of choking. Their care plan clearly stated they must be supported when eating food. Another person's care record contained a decision for close supervision, made in their best interests, to reduce potential falls. A risk assessment stated that one member of staff should always be located in the lounge, yet the person was walking around the unit with no staff present. We spent 20 minutes sitting in the lounge of Elliot unit with a person whose care records said they needed to be supervised by staff when in communal areas due to potential aggression and risks to others. However, there were no staff visible during this period which meant they and others were at risk.

People we spoke with on Kneel and Osborne units thought there were not enough staff. One person said, "There are not enough staff – it would be lovely to have enough time to talk to me and me to talk to them. One day a carer talked to me for a while and she said she enjoyed it." A relative commented, "Yesterday two carers came in at 4pm and we didn't see anyone again until 9pm. Another relative said there had been no staff available to look after their family member the previous Saturday, so staff had taken them to the unit for people living with dementia, where another person had "started to mess with their hair."

Staff we spoke with also expressed concern about staffing. One newly employed member of staff told us that on one day the previous week, there had been three staff working on the three residential units. They said, "I'm on one unit, there are two on another, therefore one unit is empty. It happens a lot. There are more staff than usual today (second day of inspection). The call bells are being answered quickly today. That's not normal. People can wait half an hour for the bell to be answered." Another member of staff told us about one person on the Osborne unit who needed one to one support to keep them safe in communal areas because they were at high risk of falls. They said the person had to stay in their room when there were not enough staff available to support them. Staff told us that weekend cover was a particular problem. We visited at the weekend and found the two nursing units, Kneel and Osborne, were short staffed because both permanent and agency members of staff had not arrived for work or were unwell. This meant there were five members of care staff on duty instead of seven. Staff were trying to find agency cover.

There were not sufficient numbers of suitably competent, skilled and experienced staff deployed to meet people's support needs. This is a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The skills mix and deployment of staff undermined their ability to take the actions required to understand and minimise risks. The provider told us that new staff were rotated around the different units as part of their induction to give them an overview of the service. However, new staff told us this made it difficult for them to become familiar with people, and their support needs. Comments included, "It upsets me because I want to be a carer. I'm on Colenzo Jones today but I don't know the people there", and, "I can't learn because I'm in every wing and all over the place". Agency staff were also moved around the different units. A relative told us, "Those bank carers they don't know what to do with [my family member], they come in and I have to show them or they leave the room. The quantity of agency staff makes it not safe".

During the inspection we spoke to staff who were providing support to people with behaviours that challenge, on the dementia wing. Two people living at the unit were at risk because of regular altercations with each other which had previously caused injury. A member of staff on this unit had just returned to work having been injured by a person living there when they had their back to them. There was nothing in this person's summary sheet to advise staff how to work safely with them except for 'has unpredictable behaviour ', and we saw a member of staff working with their back to the person. On one day there was a recently employed permanent member of staff and two agency staff, one who was working their first shift in the unit and the other their second. The newest member of agency staff was left to support people in the lounge because the 'floater' had been called away to administer medicines and the other member of staff had their break. As the member of staff was leaving the agency staff member asked them for clarification about who people were and what support they would need in their absence. The permanent member of staff told us, "It's so dangerous".

The provider was not ensuring that care was being provided in a safe way for the people living at the service. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our concerns about staffing levels and deployment throughout the inspection to the provider and managers, particularly in relation to Alford and Elliot, the two units in the dementia wing. The manager told us, "Staffing levels are safe. We are rostering in a way that is safe." The service improvement plan showed there was a 'very high staff to resident ratio', according to the dependency tool used to calculate staffing requirements. We were told by the provider's representative that improvements had been put into place to ensure people's safety on the dementia wing. A registered mental health nurse (RMN) from an agency had been booked to work on Alford and Elliot units, along with an additional member of staff, for a minimum of two months. The deputy manager provided assurances that there would now be two staff on each unit, a 'floater' (a care worker covering the two units) and the RMN. They told us they would have oversight of the dementia wing to ensure that all incidents were managed, recorded, reported and analysed using a more detailed behaviour monitoring chart. This would allow staff to better understand people's behaviour and provide care in a way which was less likely to result in an incident. Following the inspection we were informed the deputy manager was no longer working at the service and a replacement was being recruited. In the meantime, an interim deputy manager would have oversight of the dementia wing.
An audit carried out by the provider in September 2017 identified the need to review the deployment of staff to ensure that there were sufficient numbers of permanent staff within the home. The deputy manager had reviewed the rotas and was introducing a new two week rolling rota the week after the inspection, which would ensure better coverage of the units by permanent staff.

The provider confirmed that staffing was a concern at the service, with 50 percent of the workforce being agency staff at the time of the inspection. The deputy manager advised that the rotas for the weekend we visited, when the nursing wings were short staffed, had all been covered. They told us there had been issues with agency staff not turning up and this was a recurring problem. The manager had been working with agencies to develop a core team of consistent agency staff to work at the service. Three weeks after the inspection the provider informed us the number of agency staff had reduced to 44 percent.

The manager told us that recruitment was their 'biggest priority'. There had been an active recruitment campaign underway for some time and the recruitment process was being reviewed. They told us, "There is a steady flow of applications, but we have been selective. People must be experienced and ready for the role. We have had some good applicants, but some poor applicants too. A couple of new permanent staff started last week and there are some new applications again".
The provider had not always ensured people were protected from the risk of abuse. Staff received training about safeguarding adults; there was a safeguarding and whistleblowing policy in place and a whistleblowing hotline funded by the provider. However, during the inspection a member of staff told us a person had disclosed that morning some money had been stolen. The member of staff had not reported this and was unaware of the process for doing so. We directed them to inform the manager as a matter of urgency. There had been an altercation between two people which had caused injury to one person. This was documented on a body map for the injured person and in the person's daily notes, but an accident and incident form had not been completed and the incident had not been reported by staff to senior staff or the manager. This meant the incident had not been investigated or appropriate action taken to safeguard the people involved. The provider had not notified the CQC of the incident in accordance with the regulations.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our concerns about these incidents to the provider and managers. They undertook to investigate them further and take any action required to ensure people's safety. They raised safeguarding alerts with the local authority and submitted notifications to the Care Quality Commission. Following the inspection the provider advised that the safeguarding policy had been re-issued to staff and was under

review.
Since our last inspection in February 2017 the provider had made improvements to the medicine management at the service. There were systems in place to ensure people received their medicines safely, however further improvements were needed. Prescribed creams were recorded on people's medicine administration records (MARs). The information was transferred onto a topical cream chart by staff to be signed when topical creams had been administered. This guided staff which cream to use, where it should be applied and the frequency of the cream application. However the information on the cream charts was not always accurate or clear and there were missed signatures on some recording sheets. This meant there was a risk people might not have their topical medicines administered as prescribed.

People's medicines were administered by nurses on the nursing wings and senior care staff trained in the administration of medicines on the residential wings. Staff, were seen during our visits administering medicines in a safe way. They had a good understanding of the medicines they were giving out to people. Where people had medicines prescribed for pain when needed, (known as PRN), instruction sheets were in place for most of these to guide staff how they should be used. We raised with the management team that some people were taken to their rooms to have their medicines. They were not asked if they wanted to go and it was not referred to in their care plans. They said they would look into this to ensure people were being given choices about their medicine administration.

There was a system in place to monitor the receipt and disposal of people's medicines and a procedure to monitor the daily temperature of the medicine fridge and medicine storage area. Medicines at the service were locked away in accordance with the relevant legislation. Some medicines require additional security and recording. We found the quantities of these medicines corresponded accurately to the medicine records. Medicine administration records were accurately completed and any signature gaps and errors had been identified and action had been taken to ensure people had received their medicines. There were regular medicine audits carried out to monitor that medicines were being safely administered. An internal audit completed by the service on 13 September 2017 found a number of errors in the administration of medicines. The service had acted promptly and decisively to minimise the risk of future errors occurring.

At the focussed inspection in July 2017 we found risks to people's safety were not always well managed or documented. Since this inspection all care plans and risk assessments had been reviewed and risk assessments had been completed in relation to people's skin, diet and mobility. When risks had been identified, plans were in place to manage and reduce these risks where possible. Records showed that people had been weighed monthly and action taken where required. For example, one person had lost weight. Records showed the GP had been informed and staff advised to, "monitor my food and fluids intake, enrich my food with butter and cream, offer me extra desserts". We saw there were drinks in people's rooms. Prior to the inspection the deputy manager had introduced a new 24 hour fluid balance chart to monitor fluid intake. This was reviewed at each shift handover, and if a person was not meeting their fluid intake target, they were placed on hourly observations and offered a drink. Pressure relieving mattresses were set at the correct setting and there was a system in place to ensure they were checked daily.

Staff were recruited safely. Recruitment processes were thorough to make sure staff were suitable to work with people. Written references were obtained and checks had been completed to make sure staff were honest, trustworthy and reliable. This included completing an application form with full employment history, evidence of a Disclosure and Barring Service (DBS) having been undertaken, proof of the person's identity and evidence of their conduct in previous employment. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

People's needs were considered in the event of an emergency situation such as a fire, for example their mobility and the number of staff they would need to support them to exit the building safely. Regular health and safety checks were undertaken, electrical equipment was tested for safety, and legionella and temperature checks were undertaken on the water and water outlets.

Requires Improvement

Our findings

At the last comprehensive inspection in February 2017 we rated this key question as 'Requires Improvement'. This was because a lack of staff meant that people did not always receive consistent and effective care. At the inspection in February 2017 we found management had not recognised this or taken action to ensure effective support was being provided.

At this inspection in October 2017, the manager told us staffing levels were now more than adequate to meet people's assessed needs, with a ratio of one member of staff to three people. However, despite this we found people did not always receive effective care because staff did not have the competence, skills and experience to provide it.

People were negative about the support they received from some agency staff. One person, when asked if the care staff were able to meet their needs told us "No, oh god no! They're not very good at all; the quality of staff is not good. They're mostly agency staff and have been ever since I've been here. There's no nucleus of staff, no regular staff". A relative said, "Those bank carers seem to walk up and down and do nothing, not even make a cup of tea". A permanent member of staff told us, "There are good and bad agency staff. Some are willing to help. Some won't complete the paperwork, care plans, food and fluid charts, which means I have to double back to check. A couple I worked with yesterday were brilliant. The past couple of weeks there have been so many I haven't seen before. Some are unwilling and they have a negative attitude. I can't work to the best of my ability because I have to go back and double check things". People and relatives spoke much more positively about the quality of the support they received from some permanent members of staff. Comments included, "One of the carers has been really brilliant. I can't praise them enough. If only there were more like them here" and, "They are on the right track now. They have some outstanding staff who don't rush my [family member], they're great with them."

Although there was an in-house trainer and a comprehensive induction and training programme in place for permanent staff, staff told us they did not consistently receive the support and training they required to provide effective and safe care to people. The induction programme consisted of two weeks of face to face training on topics such as person centred care planning, safeguarding, dementia, infection prevention, fire safety and the Mental Capacity Act (2005) (MCA). There was also an 'experiential learning' session, which the trainer told us encouraged staff to think about how they worked with people, and how it felt for the person they were supporting.

New staff were allocated a 'buddy', and spent time shadowing more experienced members of staff. They

completed the 'Care Certificate', which is a set of recognised standards that health workers are expected to follow in their daily working life to provide safe care. We asked three new members of staff whether their induction had given them the knowledge and skills they needed to support people effectively. Comments included, "The first two weeks were good with lots of shadowing, but we were short staffed so I had no scheduled training", "Everyone is stressed and trying to do five people's jobs. There is no support for the people who have just started" and, "I'm supposed to be paired up with a buddy. It hasn't happened. I was chucked in at the deep end. I've had no formal supervision".

There was a comprehensive rolling training programme at the home, which enabled permanent staff to complete mandatory training and ensure their knowledge and skills were maintained. Information from the provider showed that in September 2017 mandatory training had been completed by 84 per cent of staff. Staff spoke positively about the quality of the training; however recent sessions in moving and handling and dementia awareness had been cancelled as there were no attendees. A member of staff told us, "There is plenty of training. I couldn't go a couple of weeks ago. We have to find our own cover so we can do the training". We raised this with the provider's representative who disputed this, however the training coordinator confirmed that the need to prioritise working with people and ensuring their safety had impacted on the ability of staff to attend some of the training sessions.

While some permanent staff told us they felt well supported and had regular supervision, this was not the experience of all the staff we spoke to. One member of staff told us, "I have supervision with a nurse and a review with a manager. It's helpful. I can raise concerns and work on issues". While another member of staff who had been at the service for five months told us they had never had supervision. The service's continuous improvement plan (CIP), showed that the provider had identified a need to improve staff induction, training and supervision in June 2017. They had been taking action to ensure greater consistency in the level of support provided to staff, however in September 2017 the CIP identified that supervision still needed to be brought to a 'compliant standard'.

There was an induction for agency staff, but feedback received during the inspection suggested this was not always effective in enabling them to support people safely. Their induction covered key areas such as the lay out of the building, policies and processes, emergency procedures, medicines and documentation. However, during a fire alarm test we spoke to an agency member of staff who told us they did not know what the noise was or what to do. They told us they had not had any training in how to respond in an emergency, and this was their fourth shift at the home.

Following the focussed inspection in July 2017 the provider wrote to advise "an agency file is now in place… which includes confirmation of all training attended so they can ensure that they [agency staff] can be deployed throughout the home according to their skills and prior knowledge of the residents". However, records showed that in October 2017 this information had not been requested for three of the agency staff we spoke to, including one member of staff, working their first shift on the unit with people who had behaviour that challenges. This meant the provider did not know whether this person had the skills and knowledge to support people safely.

The provider told us it was the responsibility of the agencies to provide supervision and training to their agency staff working at the home. However, one of the regular agency staff we spoke to told us, "I have a shift leader to go to but no supervision meeting, and no support from the agency… At least seven to ten agency staff are around a lot. We write on the care needs. I need feedback about whether I'm doing it right."

Staff did not consistently receive the support, training and supervision required to meet people's needs effectively. This is a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

We discussed the issue of supervision and training for agency staff with the deputy manager. They told us they would look at the skills and training of agency staff, and at how they could be more involved in the training provided to the permanent staff, "So we're consistent." They responded to concerns about the effectiveness of the induction by adding 'getting to know me' sessions, to the induction programme where new staff could spend dedicated time reading care plans and learning about the needs of the people they would be supporting.

The service aimed to ensure that people's specific dietary needs were met and their choices respected as far as possible. Information about people's dietary needs was sent through to the kitchen each day. Where there were concerns about a person's nutritional intake advice had been sought from relevant health professionals who had provided guidance. For example, providing thickened fluids or pureed food for people at risk of choking.

People chose to eat in the dining room or in their room if they wished. They spoke very positively about the quality of the food and choices available. Comments included, "I love the food here – I really do. They give you choices. They're incredible and I don't know how they do it", "The food is very good, they give me what I want, what I like" and, "It is very good here. I have soup and fish every day." We saw written feedback from a relative which said, "The restaurant service is amazing. I have joined [my family member] a few times for lunch, the staff know everyone's name, take great care in asking what they would like, know their preferences in advance, wine and soft drinks on the table. It's just like going out to lunch. All the staff make it a very enjoyable experience." A daily menu was displayed outside the main dining room, tables were laid with clean linen, and people had napkin rings with their names on them. Some people were enjoying a glass of wine with their meal.

The kitchen assistant waited until people had finished their main courses before talking to people at their table to ask what they would like to eat the following day. We later heard care staff visiting people in their rooms to take their food order for the next day, and a member of staff offering people cake which had been made by their spouse.

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. Staff had received training about the MCA and told us how they applied its principles to their practice to support people in their decision making. 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. Care plans showed that people's capacity to consent to their care and treatment had been assessed, and decisions made in their best interests where required. For example, we saw best interest decisions had been made related to the use of pressure mats to alert staff if people got out of bed, or to allow staff to closely monitor a person's of personal and nutritional needs to ensure they would be met.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed 33 people had been referred for an assessment under DoLS as required.

People's health needs were monitored and action taken to address any concerns or changes. A communication book was available for visiting professionals such as GP's and community nurses to

document visits and the advice given. However, this system was not effective because visiting professionals and staff did not consistently use it. This meant information about people's health needs was not always exchanged between the service and health professionals. The service and the GP practice were working together to resolve the issues with communication. A visiting community nurse told us, "We have been working alongside each other to make sure people get holistic care. Here they are very open and good, and I am sure they would contact me with any concerns".

Requires Improvement

Our findings

At the inspection in February 2017 we found staff were unable to ensure that people's dignity was maintained at all times. This was a breach of the regulations. We rated the service as requiring improvement in this area. Following the inspection the provider sent us an action plan and told us how they would address these concerns and by when. At this inspection in October 2017 we checked whether improvements had been made. People told us the majority of staff treated them with dignity and respect, however, during the inspection we saw that people's privacy and dignity was not always respected. On five occasions when we were talking to people in their rooms members of staff walked in without knocking and without saying 'excuse me'. We raised this with the provider's representative, who provided reassurances this would be addressed with staff. We saw a member of agency staff giving a person a bowl of cold porridge for breakfast. We intervened and the porridge was warmed up for the person. We raised our concern with the manager.

Care plans did not document people's end of life wishes or provide the information staff needed to support them according to their wishes and preferences. During the inspection a member of staff expressed concern about one person who was sleeping a lot and not meeting their target intake for fluids. We raised this with the deputy manager and team leader, who advised the person was receiving end of life care. Staff had been unaware, as this was not documented in the person's care records and there was no care plan to guide staff as to how this person should be supported. This meant there was a risk that staff would not provide person centre care which respected the person's wishes and preferences at the end of their lives. The deputy manager added the necessary information to the person's summary care plan.

People's care plans did not always document how their end of life needs should be met. This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff were too busy to spend time with them. One person said, "Many years ago the staff were really good but then it changed. It was a good change when they started getting agency staff because there was an increase in the number of staff, but the old days staff were better than these days, modern ones, because they had more time to spend with the residents." Another person said, "Staff don't have time to chat, except on Sunday mornings", and a relative described their family member as "a bit lonely". Staff told us they were frustrated at not having the time to support people in the way they wanted to. Comments included, "I have no time to sit with [person's name] with a biscuit, who is at risk of choking", and, "We haven't got enough time. It's rushed, in order to make sure everybody's looked after the best they can".

We found staff did not always know the people they cared for which meant they were not always able to

support people in line with their individual preferences. For example, the care plan of a person living with dementia stated, "I don't like bingo. I don't like big groups, noisy activities. The noise upsets me". However, a member of staff approached the person saying they would take them to bingo and told us the person 'loved it'. Another member of staff stepped in and said it was the person's choice and proceeded to ask them if they wanted to go. The person declined.

Newly employed staff and agency staff told us they found it difficult to get to know people and how they wanted to be supported because they did not work consistently in the same units. One member of agency staff told us, "It's short staffed so we get moved around a lot". They had been working at Cadogan Court for two months and told us that although the summary of people's needs they were given was useful, "It doesn't tell you about personality or how to approach them. I wasn't encouraged to read the care plan and notes about them". The summary sheets contained information about people's physical care and communication needs but no information about personal history or individual preferences.

The permanent staff we spoke with, who had been at the service for some time, had a good knowledge of the individual people they supported, and were able to tell us about people's likes, dislikes and particular interests. For example, one member of staff described how they worked constructively with a person who refused to be supported with personal care. They were able to ensure the person's needs were met, while also understanding and respecting their wishes as far as possible. The manager told us the provider had a keyworker policy which would mean people had a designated member of staff with responsibility for ensuring their needs were understood and met. However, they told us this was not currently operating due to a lack of regular staff. They planned to reintroduce this once a more stable staff team was in place.

All but one person told us staff were kind and caring. Comments included, "The care? It's absolutely, absolutely good, couldn't get any better, they're ever so kind", " I love it here, I am really happy, I like the door open lots, people say hello as they walk past" and " [Family member] is very happy here, they wouldn't want to be anywhere else. Staff are really friendly". Written feedback from a relative stated, "We would like to express our delight that [staff member] has undertaken to be [family members] key worker. They always make the time to speak with [family member] and with any one of us when we visit."

Care plans prompted staff to use people's preferred names, and we heard them being addressed by staff in this way. One person was supported with showering, and told us they had had a shower that morning. They looked well kempt and comfortable with their hair and nails done as they liked them. They told us the care staff were respectful towards them saying, "They're wonderful. I've no worries or concerns at all, they are always polite".

We observed that staff showed concern for people's well-being in a meaningful way and supported them with patience and kindness. For example, one member of staff was asking a person what they would like for breakfast. They sat at the person's level, waited patiently for the person to give their response and brought them what they had requested. We heard another member of staff reassuring a person. They were calm in their approach.

People told us they were able to make decisions about how they wanted to be cared for, including where they spent their time, what they wore and where they ate. We saw people moving independently around the home, and enjoying spending time in the reception area reading a newspaper and chatting to people passing by. Staff supported people with decision making, such as choosing what they wanted to eat the following day. Written feedback from a relative said, "Such kindness, consideration, patience and care. I see it every time I visit [my family member] usually twice a week. Even with dementia, the carers always ask them what they would like to do and even when they change their mind a few times, they are very patient

and make sure things happen for them".

Requires Improvement

Our findings

At the inspection in February 2017 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 or be supported to organise their own activities if they wanted to, due to inadequate staffing levels. This was a breach of the regulations. We rated the service as requiring improvement in this area. At the focussed inspection in July 2017 we found people's social and emotional needs were being met. However, we found another breach in regulation because the provider had not ensured people received care and treatment which was appropriate and met their needs. We again rated the service as requiring improvement in this area. Following the inspection we wrote to the provider to request information about the action they intended to take to address these concerns and received a satisfactory response.

At this inspection in October 2017 we checked whether improvements had been made. Since the last inspection the provider had taken action to ensure people received care and treatment which was appropriate and met their needs. There had been a review of all care plans and risk assessments. As a consequence they were more person-centred, and there was clearer guidance for staff about how to meet people's individual needs. However, this was not consistent.

Care plans employed a 'tick box' format for recording people's personal care needs, which meant individual preferences were not documented relating to support with oral care or bathing. There was no record of people being asked if they preferred male or female carers for personal care. One person had glaucoma. Although their care plan mentioned the condition there was no guidance for staff about the impact of this on the person, or the support they needed to manage it. A person with a urinary catheter had no catheter care plan, no record of when the bag had been emptied or changed and no guidance for staff about how to support the person. A relative had expressed concern that their family member was severely visually impaired and had hearing loss, yet there had been no reference to this in their care plan. They had instead been assessed as having cognitive decline and a limited ability to communicate, when their difficulties were because they could not recognise the faces or voices of care staff. This meant, care staff were not informed about the support the person needed with communication or their risk of becoming isolated. The care plan had subsequently been rewritten with the assistance of the person's family.

People's care plans did not always document how their needs should be met. This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our concerns about the lack of consistency and accuracy in the care plans. The provider's

representative reassured us they would take immediate action to address them.

Other care plans had been updated since the last inspection and now contained good person- centred information for staff to follow. We reviewed the care plans of people living with dementia and found they contained more detailed guidance for staff about how to support people with behaviour that challenges. For example, "Wherever possible ensure that staff who know me well provide personal care and continence care intervention, be patient with me, walk with me, offer me reassurance. Encourage me to accept care intervention." We saw this approach being used successfully by a member of staff. This care plan also guided staff to inform the shift leader if the person had refused support.

Three members of permanent staff told us the care plans were too detailed and they didn't have time to read them. Comments included, "There's too much paperwork. There is so much information in the care plans", "I have not had chance to read them I haven't got the time" and," I have picked up more from working with the residents than reading about them". This was confirmed by a relative who said, "My [family member's] care plan was overly complicated and agency staff would have too much to read to understand their needs. This carer even spent some of their own unpaid time helping us completely rewrite and simplify it." The provider had produced a summary of the care plan, with a photograph of the person, to enable both permanent and agency staff to easily access information about the people they were supporting. This was updated regularly by the shift leaders and senior carers, and staff told us the document was clear and helpful. The manager told us, "I'm happy people have the opportunity to understand the needs of people". A new electronic care planning system was due to be introduced in line with the providers other homes, which the manager said would simplify the care planning process and make it more efficient. They said, "We will change to the electronic care planning system, but we need a strong and stable staff group in place first or it would overload people".

Care plans were reviewed monthly and when people's needs changed. Daily handover meetings were used to update staff about any changes in people's needs. One person had recently returned from hospital after surgery, and we saw their risk assessments and care records had been updated to reflect the changes in their needs. Some relatives said they had contributed to a review of their family member's needs, although this was not consistent. One visiting relative told us, "I can't remember when I last saw [the care plan]; generally I wouldn't bother with it". Written feedback from another relative said, "We had the opportunity to read the care plan together for the first time since my [family member] moved to Cadogan." The deputy manager told us a 'resident of the day' programme was being introduced, which would enable staff to gain a more detailed understanding of the needs of the person, and their relatives would be invited in to review their care plan.

At this inspection in October 2017 we found the service had acted to ensure it was fully responsive to people's social and emotional needs. The provider's representative told us, "We have a revamped activities programme. We have done a lot of work around activities and have an additional activities worker". A member of staff confirmed, "There are more activities now. They can choose if they want to do them or they can go out. It's disappointing if they want to stay in their rooms. We are encouraging them a lot". The manager was documented in staff meeting minutes as saying, "It is health and social care and we need to be encouraging the residents to join in and socialise. Residents shouldn't be spending their whole day in their room and it is vital that we encourage them to leave their room to socialise, in order to keep them active".

The home had an activities programme run by three activities co-ordinators. During the inspection we saw an exercise session taking place attended by seven people. A monthly newsletter informed people of the activities programme and upcoming events. There were scheduled 'one to one' sessions for people being cared for in their rooms, church services, a mobile shop, trips out in the minibus and visiting speakers.

People made crafts to sell at summer and winter fairs and there was a bar in the home where one person told us they enjoyed going for a drink and socialising. People were invited to make suggestions about activities they would enjoy at an 'activities' meeting. The development of the activities programme was ongoing and a plan of activity was proposed for people living with dementia, based on their life history and previous interests.

Since the last inspection in July 2017 the provider had taken action to improve the quality and responsiveness of the care provided to people living in the dementia wing. A 'dementia care mapping' exercise had been carried out by the provider's dementia specialist. Dementia care mapping is an observational tool used to evaluate the wellbeing and emotional state of people living with dementia. This process enabled the provider to identify what kind of support was working well for people living in the unit and what could be improved. An action plan was being developed and was in the process of being implemented at the time of the inspection. Staff had recently attended training on 'de-escalation', to give them the knowledge and skills to safely prevent a person causing harm to themselves or others. Further training was scheduled with the provider's dementia specialist. Monthly reviews were also planned with the dementia specialist to discuss the support being provided to the people living with dementia to ensure it was effective in meeting their needs and keeping them safe.

The service had a policy and procedure in place for dealing with any concerns or complaints. The policy stated, "Our goal is to ensure that any person using our services who raises a complaint, including a complaint raised by a person acting on their behalf, are supported by our homes and our staff". A relative told us, "If we have any concerns we can tell them and they will act on them". We saw that formal complaints had been dealt with in line with this policy. However, during the inspection we were contacted by two relatives who expressed frustration at the lack of response from the manager when they had rung to discuss a concern. One relative said, "My family and I remain satisfied that our mother is safe and well cared for, but we have little confidence in the management or responsiveness of the service overseen by the RMBI (Royal Masonic Benevolent Institution)"

Inadequate

Our findings

The service continues to be poorly led. While the provider has identified where improvements are needed, people were not protected by the provider's systems and processes to monitor the safety and quality of their service.

At the inspection in February 2017 we found that the provider had developed an action plan to address failings identified in the service following a period where there had been no leadership. However, the systems in place had not shown sustained improvement and did not ensure the concerns were identified and managed effectively in order to maintain the safety and quality of the service. We rated this key question as inadequate. We took enforcement action by serving a warning notice around their quality monitoring systems.

At this inspection in October 2017, we found that despite the progress indicated by the provider in meeting the targets identified in their continuous improvement plan (CIP), there remained significant shortfalls in the management of the service. People continued to be at risk and the quality of the service was still not maintained, as identified in this inspection report. This meant the warning notice was not fully met. The provider's representatives told us, "We don't feel this service is unsafe. We can see improvement from the CIP. We understand there is a lot to do and it takes time, determination, energy and effort" and, "We know we are on a journey. Things aren't perfect. Managers and middle structures have come and gone. It's hard for people on the floor. We need a period of time to take it forward."

After the inspection in July 2017, a new manager was appointed following the resignation of the previous registered manager. They told us they would be submitting their application to CQC to register as the registered manager. In October 2017 this application had still not been made, which meant there was no registered manager at the service.

The provider had a programme of audits in place, and since the last comprehensive inspection in February 2017 had begun to implement a range of quality assurance measures, to monitor the quality and safety of the service. However, these processes had not identified some of the issues we found during our inspection, or ensured action was taken to address them. Concerns around safe staffing levels and the deployment of staff had been raised consistently during CQC inspections at the service since July 2016. The CIP showed that since June 2017 the manager had reviewed dependency levels, staffing, agency use and deployment. This work was ongoing. A dependency tool was being used to calculate staffing levels, and during the inspection the manager reassured us staffing levels were safe. However, there were five occasions during the

inspection when no staff were present in the communal area of Alford unit. The people living there had been assessed as being at risk due to falls, choking or behaviour that challenges. An agency member of staff was left to cover this unit on their own on their first shift, so other staff could have a break. Staff had not arrived for work when we visited at the weekend which meant there were five staff working on the two nursing units instead of seven. This meant one person on the Osborne unit, who was at high risk of falls, had to stay in their room until there were enough staff to provide the one to one support they needed in communal areas to keep them safe.

Electronic spread sheet 'trackers' were in place to collate information in relation to a range of issues and activities including accidents and incidents, wounds, assessments under the Mental Capacity Act 2005, DoLS applications, risk assessments and care plan reviews. This information enabled the provider to track and monitor any issues affecting the quality and safety of the service, and identify any actions required to keep people safe. However, incidents were not always reported by staff which meant the process was not fully embedded or effective. For example, a 'falls tracker' was introduced in June 2017 to document falls. This information was subsequently analysed at a 'falls meeting', to ensure action was taken to minimise people's individual risks and to help keep them safe. However, falls documented by staff in care records had not always been reported and recorded on the tracker. An altercation on Alford unit between two people had caused bruising, but had not been reported by staff or included on the tracker. This meant protective actions could not be identified and put into place using this system. We raised this with the manager who confirmed there had been, "failings in accident and incident reporting which included falls and subsequent analysis". They advised that the falls meetings had been introduced as a means of managing the falls, "although it then took some time for reporting, recording and analysis to improve". During the inspection several members of staff told us the home had run out of incontinence pads, and this was a frequent occurrence. We raised this with the deputy manager who was unaware of the issue. They told us, "The systems and processes are there, but we need to close the circle. Some of the systems and processes weren't happening and working".

The provider's representatives visited the service once every week to support the manager and monitor the progress of the CIP. This allowed them to identify what had been achieved and which actions were still outstanding. In addition, they carried out a comprehensive quarterly audit of the service, which was based on the CQC's key lines of enquiry (KLOEs). The most recent audit on 05 September 2017 identified that medicines were not being managed effectively and administered safely. Action had been taken and this was no longer the case at the time of the inspection. However, concerns about staffing levels and deployment were also identified and this remained an issue at this inspection. This meant that although the audit had identified failings, action had not consistently been taken to ensure the quality and safety of the service.

Staff expressed concern that the provider and managers did not have a clear understanding of the issues affecting the quality and safety of service provision. Comments included, "There are too many agency staff. The new management team won't get anywhere until they get their own team in place. We don't see management unless we come to meetings which are held in the day time and if you are working nights that isn't possible. The management used to work on the floor and knew the problems we faced. We have new paperwork but no one tells us how we have to fill it in", "Management need to be more supportive. We understand they have their own responsibility and job role, but they need to see how it is on the shift. They don't realise how hard it is and what the shift is like… They need to understand the reality" and, "We need more people on the floor and a structure needs to be put into place."

Whilst the provider has responded and reacted immediately and favourably to issues identified during the inspection, their own quality monitoring systems should have enabled them to identify these issues and to respond in a proactive way. This continues to be an area of concern.

The provider had systems in place to monitor and improve the quality and safety of the service; however these systems continued to be not fully embedded or effective. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared our concerns about staffing with the provider's representative. They acted immediately to address our concerns about staffing levels on the two units in the dementia wing by recruiting a registered mental health nurse (RMN), along with an additional member of staff, for a minimum of two months. This meant there would now be two staff on each unit, a 'floater' (a care worker covering the two units) and the RMN. The manager was working with the agencies to develop a core team of consistent and reliable agency staff. This was confirmed by agency managers who commented, "For the first time this week they are booking ahead rather than phoning on a day to day basis", and, "There have been some considerable improvements with the new manager. We are able to send regular carers. We are working really hard to support them and provide that consistency". Rotas were due to be changed immediately following the inspection to ensure a more even spread of permanent staff across the units so that agency staff would not be working alone. Recruitment was on-going. In addition, the manager told us that proposed changes to the lay out of the home would provide a better structure for the care of people living with dementia and help with the deployment of staff.

Overall, staff were complimentary about the manager and felt there had been some positive changes at the service. Comments included, "I do enjoy working here, it is challenging at times. Improvements were needed and some have been made", "The new manager is motivating us a lot. I'm happy with this. The previous manager wasn't listening" and, "I have a huge amount of confidence in [manager's name]. They are calm, confident and exude poise. They don't lose their temper. It's a shame they can't spend more time on the floor, but they're busy doing other things."

People living at Cadogan Court were aware there was a new manager in post, but told us they did not see them very often in the service. Comments included, "There's no access to the manager", "I had great hopes for the new manager, I've only seen them once, we can only hope" and, "I think I've met them. I think he or she came into the dining room once."

The manager told us their values were about treating people with kindness and respect. They said, "I want people to feel safe, happy and content here. I would like us to achieve a rating of outstanding and all that goes with that, in the systems of work and the way we deal with people". They told us that although they "would like to spend more time out and about" they did have an oversight of the service, visiting the units three times a week for "recording and learning purposes" and spending time in the units "most days". They also met with senior staff every morning to discuss any issues. The manager said they were working to change the 'negative' culture of the service, which they anticipated would take two or three years. They told us, "There is an entrenched culture here. We need to get staff on side. Do team building. It's about giving responsibility to staff. Their roles were devalued. Staff have begun using the systems in place, however some staff have been here for 20 years and we are asking them to change the way they work. Previously people were expected to deal with things themselves. Now there is a fairly robust system in place. They haven't seen communication channels here, now there are".

The manager said the staff team had been under a lot of pressure due to the scrutiny of the safeguarding process. They told us, "The contentment of staff is important. I want people to feel happy to come to work. People who don't feel that are starting to depart the scene and choosing to move on". They operated an 'open door' policy, and staff were invited to express their views and air their concerns at monthly staff meetings and informal tea and cake sessions. A monthly newsletter kept staff informed about developments at the service. Staff meeting minutes showed that on 28 September 2017 the manager had told staff the

service was making good progress and they should be proud of what they did. A staff member was presented with an award from the provider, in recognition of their hard work. Staff were encouraged to come forward and speak to management if they had any concerns.

People's views and the views of their relatives were sought via an annual survey, and at regular residents and relatives meetings. Minutes of a relatives meeting on 12 October 2017 showed that the manager had shared information with relatives about the safeguarding process, CQC inspection rating and staffing difficulties. They had provided updates about the action being taken at the service. There had been an open discussion and the opportunity to ask questions. Relatives had also raised concerns about their family member's laundry being properly labelled, and the CIP showed that action had been taken to address this.

Throughout the inspection, the managers and providers representatives were quick to respond to the concerns raised. They demonstrated an open and transparent approach, for example showing us what they had identified themselves as already requiring improving. This demonstrated their understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. The provider had displayed their latest rating in line with legislation.

There were continuing changes in the management team which the provider told us would strengthen the management structure. The clinical lead had left the service and there were now two deputy manager posts, one with responsibility for the nursing and dementia units and the other for the residential units. Following this inspection one newly appointed deputy manager left the service, so an interim deputy manager was supporting the home until the new deputy managers were in post.

The manager kept their own knowledge and skills up to date, attending Royal Masonic Benevolent Institution (RMBI) events and conferences and meeting regularly with other managers to share information and ideas about best practice.