The Royal Masonic Benevolent Institution

Prince George Duke of Kent Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 01 and 03 December 2015 during which breaches of legal requirements were found. We took enforcement action, serving warning notices in respect of breaches found of Regulations 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We undertook this unannounced focused inspection of the service on 06 May 2016 to check that the requirements had been met in response to the enforcement action we had taken. This report only covers our findings in relation to those requirements.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Prince George Duke of Kent Court on our website at www.cqc.org.uk.

Prince George Duke of Kent Court is a nursing and residential home providing accommodation, care and support for up to 78 people. At the time of our inspection there were 72 people living at the home.

There was a registered manager in post at the time of our inspection. 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.

At this inspection we found that action had been taken to address the breaches of regulations 10 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People told us their privacy was respected and this was confirmed by our observations of staff working practice. Records were up to date and reflective of people's current needs and preferences. Records were also stored securely and staff were able to locate them promptly when requested.

However, we also found a breach of regulations because the registered manager had failed to submit statutory notifications as required by the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service caring?

Requires Improvement

We found that action had been taken to ensure the service was caring.

People were treated with dignity and their privacy was respected.

We could not improve the rating for 'Is the service caring?' from 'Requires improvement' because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service responsive?

Requires Improvement

We found that action had been taken to improve the responsiveness of the service.

People's care plans reflected their individual needs and preferences. Accurate records had been maintained relating to people's care and treatment.

We could not improve the rating for 'Is the service responsive?' from 'Requires improvement' because other areas of this key question required improvement based on the findings of our last inspection. We will check on whether these improvements have been made during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements had been made to ensure people's records were securely stored and accessible when requested.

However, the registered manager had not always submitted notifications to the Commission where required to do so.

Prince George Duke of Kent 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.

We undertook an unannounced focused inspection of Prince George Duke of Kent Court on 06 May 2016. This inspection was done to check that improvements to meet legal requirements after our 01 and 03 December 2015 inspection had been made. The team inspected the service against parts of three of the five questions we ask about services: is the service caring, is the service responsive and is the service well led? This is because the service was not meeting some legal requirements

This inspection was undertaken by an adult social care inspector. Prior to the inspection we reviewed the information we held about the service and the provider. This included notifications received from the provider about deaths, accidents and incidents, and safeguarding allegations. A notification is information about important events that the provider is required to send us by law. We also contacted the local authority commissioning team responsible for monitoring the quality of the service and the local safeguarding team for their feedback about the service. We used this information to help inform our inspection planning.

During our inspection we spoke with eleven people, four staff and the registered manager. We looked at records, including eight care records and other records relating to the management of the service. We also observed the way in which care and support was delivered by staff.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 01 and 03 December 2015 we found that some staff failed to respect people's privacy with their actions. For example, people told us that staff did not always knock before entering their rooms and we observed staff entering people's rooms without knocking, or failing to wait for a response before entering. These issues were in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet the regulation.

At this inspection on 06 May 2016 we found that improvements had been made and that the requirements of the regulation were met. People we spoke with told us that staff treated them with dignity and that their privacy was respected. One person said, "I've no concerns about privacy; the staff are all great." Another person told us, "The staff are always polite and knock before coming in [to their room]; I'm very happy." A third person commented, "The staff don't disturb me when I'm in my room."

The registered manager explained that they had introduced a new protocol for staff to follow before entering people's rooms. She explained that staff had been given specific guidance on the amount of time to wait for a response before entering. Staff we spoke with confirmed they were working in line with the new protocol to ensure people's privacy was respected. Records showed issues relating to people's privacy and dignity had been discussed during meetings with staff, residents and relatives to raise awareness of the previous concerns and ensure improvements were made. We also observed staff knocking on people's doors and waiting an appropriate time for a response before entering throughout the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 01 and 03 December 2015 we found that records relating to people's care and treatment did not always provide accurate information about their needs and preferences. For example, people's care plans had not always been edited from the care planning template used by the service so offered contradictory information about the level of support they required in areas such as personal care. We also found that records relating to the level of support people received at night were not always accurate or available so we were unable to determine whether they were receiving support in line with their identified needs. These issues were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet the regulation.

At this inspection on 06 May 2016 we found that improvements had been made and that the requirements of the regulation had been met. People's care plans were individualised to their needs and contained information regarding their life histories, likes and dislikes and details of the people and things that were important to them. Care plans had been developed based on an assessment of people's needs in areas including nutrition and hydration, personal care, mobility and medication. Each area within the care plan included information about the level of support each person required as well details of their individual goals and wishes. Records showed that people had been involved in reviews of their care plans to ensure they remained reflective of their current needs and preferences.

We also found that staff had maintained accurate records relating to the level of support people had received including the care provided at night time and information about people's food and fluid intake to ensure they received sufficient nutrition and hydration. Daily records relating to the care and support provided to each person had also been maintained. These contained details of any key events that had occurred and information about their current condition which helped demonstrate that they were receiving support in line with their preferences and assessed needs.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 01 and 03 December 2015 we found that records were not always well managed or securely maintained. Staff were not always able to locate recorded information relating to people's care when requested and we found records relating to some people's care records loose in a desk drawer which made it difficult to identify who they related to. These issues were in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action and served a warning notice on the provider and registered manager, requiring them to meet the regulation.

At this inspection on 06 May 2016 we found that improvements had been made and the requirements of the regulation had been met. Staff were able to locate records promptly when requested. They told us they had received additional training on how to use the provider's IT system and were able to talk through the way in which records relating to people's care were created and stored. Records were securely maintained on the provider's electronic database and any paper records received by the service relating to people's treatment were promptly scanned into the system. This ensured that staff were able to access a single central record providing all relevant information relating to each person's care and treatment.

However, we also found that in the time since our last inspection the registered manager had failed to submit two statutory notifications to the Commission, the first relating to an allegation of abuse and the second relating to a serious injury sustained by a person living at the home. This was a breach of the Care Quality Commission (Registration) Regulations 2009. We spoke to the registered manager about this during our inspection and they submitted the relevant notifications following our inspection.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications relating to serious injuries sustained by people using the service or allegations of abuse had not always been submitted to the Commission as required. Regulation 18(1)(2)(a),(e).