South Tyneside MBC

Connolly House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on the 18 May 2015 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 21 May 2015 and was announced. We last inspected the service on 28 January 2014 and found the provider was meeting all legal requirements we inspected against.

Connolly House is a care home run by South Tyneside MBC. It is set in a mainly residential area. It has good access both into and outside of the property with a secure courtyard available for people to use. It is registered to provide accommodation for people and their nursing needs are met by the local community nursing services.

At the time of the inspection there were nine people living at Connolly House, some of whom were living with dementia.

There was an established registered manager in post at the time of the 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.

Summary of findings

People told us they felt safe living at Connolly House. Staff were knowledgeable about safeguarding people and knew what to do if they felt someone was being harmed or at risk in any way.

Relevant risk assessments were in place which detailed the precautions and control measures that were in place to minimise any risks that may be present for people. This included the assessment and management of any health and safety risks which may be present in the environment.

Fire evacuation procedures were in place and the building plan highlighted where firefighting equipment was available as well as showing the vacant rooms in the building. Each vacant space had been risk assessed for security and maintenance issues dealt with on an ongoing basis.

Each person had a personal emergency evacuation plan and staff were able to describe in detail how they would evacuate people dependent upon their location and the location of any suspected fire.

A range of health and safety checks were completed to assess the safety and suitability of the premises and robust contingency plans were in place should there be emergencies in relation to utilities, staffing levels or the use of the building.

We were told that there were sufficient staff to meet the needs of the people living at Connolly House and we observed that all staff, including the ancillary staff and registered manager were able to spend quality time with people talking with them and engaging in activities. Staff were proactive in engaging with everyone in the room.

There had not been any recent recruitment but effective procedures were in place and existing staff had their disclosure and barring checks updated every three years.

Medicines were administered safely and effectively. Staff knew how people preferred to take their medicines and were robust in their checking of medicine against MAR charts before they administered any medicines. Procedures were in place for 'as and when required' medicines and staff were proactive in informing doctors if people weren't using this medicine as intended.

Staff were trained in medicine administration and competency checks were completed by the registered manager and the dispensing pharmacist.

Staff told us they were supported by the registered manager and senior staff and that all worked well together as a team. Regular supervisions were held with staff and all staff had received an annual appraisal. Training was discussed at every supervision and staff had attended courses in compassionate care, oral hygiene and supervision training as well as mandatory training in moving and handling, safeguarding, and dementia. All the senior care staff acted as nutrition champions and ensured people received healthy, well balanced, enjoyable meals was high on everyone's agenda.

Relevant DoLS authorisations were in place and the staff team understood what this meant in relation to the care people received. The team had received positive feedback from a best interest assessor who had spent time at the service assessing someone recently.

We were told that no one presented with behaviour that challenged the service. Care plans were in place for people who may show distressed or agitated behaviour and staff were aware of the triggers for this behaviour and managed it well which meant people were reassured and remained calm.

Specialist advice had been sought where needed in relation to people's dietary needs but also in relation to their mobility needs and general health and welfare. The staff told us that there were positive relationships with people's doctors and district nurses.

We spent time observing the care that was offered to people. We found staff to be very respectful and sensitive to people's needs. Staff knew people well and used this knowledge effectively to engage people in conversation and activities and to reminisce with people. People were able to tell us about family members using photographs as prompts to recall precious moments and memories.

There was information available on advocacy services but staff explained that these weren't being used at the moment as people had active and supportive family contact.

People's care records were personalised to their specific needs and preferences and were regularly reviewed and updated. The registered manager said, "Sometimes we update them on a daily basis as people's needs can change that often."

Summary of findings

There were a range of activities on offer including pet therapy, external entertainers, and trips out, arts and crafts, singing and reminiscence as well as gentle exercise. People who had an interest in gardening were encouraged to grow plants and tomatoes. The service also had its own cinema room and sensory room.

There were opportunities for people, their family members and staff to provide feedback. This was done by way of thank you cards and a comments book for family members as well as a satisfaction survey. Staff said they did not need to complete a survey as they felt able to share any comments openly with the managers and senior staff.

There had been no formal complaints made since the last inspection but there was a log in place and the registered manager was able to describe the process they would follow if they did receive a complaint. Several thank you cards and compliments had been received.

The culture was described as being, "caring and learning." The atmosphere was relaxed, friendly and homely. Staff cared for people in a very professional, respectful yet friendly way.

Regular staff meetings were held with discussions about people being given priority alongside dignity and respect, compassion in care, dementia, health and safety and safeguarding.

A range of audits and quality assurance systems were in place to ensure the care provided and the systems used to record care practices were continuously improving and that a high quality of service was provided for all people living at Connolly House.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff knew how to report any concerns about people being harmed and there was information on display around the service.

Relevant risk assessments and emergency plans were in place including information on evacuation procedures which staff had a good understanding of.

Medicines were stored, administered and managed in a safe way with staff having good knowledge of people's medical needs.

Is the service effective?

Good

The service was effective. Staff had the knowledge needed to support people well and were seen to be using this knowledge to improve the service they provided for people.

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were understood and people had appropriate authorisations in place.

The service had recently met all expectations of the food first assessment and staff worked to ensure everyone's nutritional needs were understood and met.

People had access to a variety of health care services and the service had positive relationships with doctors and district nurses.

Is the service caring?

Good

The service was caring. Staff were respectful and compassionate in their interactions with people, treating people with sensitivity and discretion.

Staff were very knowledgeable about people's history and life stories and engaged in conversation with people about the things that were important to them.

One relative said staff are, "Second to none – excellent." One person said, "I couldn't do without her."

Is the service responsive?

Good

The service was responsive. Staff were person centred in their approach and we found care records to be individual to the needs and preferences of the people they supported.

A range of activities were on offer and these were used as opportunities to reminisce with people and chat about their interests.

There were opportunities for people to provide feedback and raise any concerns or complaints; we found the feedback provided was very complimentary and positive.

Is the service well-led?

Good

The service was well led. Staff and managers described the culture as one of transparency and openness, working together to achieve the best for people.

The senior care staff, registered manager and senior manager worked together to complete a range of audits which all served to improve the quality of the service provided for people.

Connolly House

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 18 May 2015 and was unannounced. A second day of inspection took place on 21 May 2015 and was announced.

The inspection team included one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

During the inspection we met with all nine people who lived at the service. We spoke with seven members of staff including the registered manager, care staff, senior care staff and ancillary staff. We spoke with two relatives and we contacted the local authority safeguarding team and commissioners of the service to gain their views. They had no concerns about the service and described staff as having a 'caring and compassionate approach.'

We looked at two people's care records and three staff files including recruitment information. We reviewed medicine records and supervision and training logs as well as records relating to the management of the service.

We used a Short Observation Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We looked around the building and spent time with people in communal areas.

Good

Is the service safe?

Our findings

People told us they felt safe living at Connolly House. One relative said, "I'm happy her being here, she's safe here, I'd sooner her be here than on her own."

A safeguarding log was in place and recorded any issues, action taken and the outcome of the concern or alert. We saw that action taken included informing family members and social workers; referrals to the doctor or district nurse, the moving and handling assessor as well as a review of care plans and risk assessments.

There was information on safeguarding and whistle-blowing on display around the service and the multi-agency guidance was available in the office. The registered manager said there had not been any whistle-blowing but was able to describe the procedure they would follow should a concern be raised.

One staff member said if they had any concerns, "I'd go to the office and report it then if I wasn't happy with what they did I'd go a bit further, but I think I'd be happy with what the office said to do, they are good you know."

Risk assessments were completed and reviewed appropriately. One person's mobility risk assessment added additional information that the person's blood pressure dropped on standing which was also a risk. Precautions to take were documented and the risk assessment was reviewed monthly. We saw there was information on who to contact should any equipment the person used be faulty.

Risk assessments were in place for people who may be at risk of choking and we could see that specialist advice had been sought from speech and language therapy (SALT). This assessed the risk and the precautions were documented in relation to support that was needed such as information on the correct siting position, that the person was to have a mashable diet, normal fluids, no mixed consistency of food or crumbly biscuits. The action staff needed to take if the person did choke was clearly documented.

Falls monitoring was in place as was an accident and incident book. Body maps were used to record any injuries to people, or any unusual marks staff had noted. We saw that audits and analysis of falls and accidents and incidents were completed regularly by the registered manager.

Each person had a personal emergency evacuation plan (PEEP) which was regularly reviewed. This recorded the rooms the person used, their level of awareness and any sensory needs they may have in relation to hearing the alarm. There was then information on whether assistance from staff was needed and if so how this should be provided and what equipment was needed to support the evacuation. The evacuation action plan had recently been reviewed and included safe areas for people to use as well as how the evacuation should be carried out and primary and secondary routes for escape. Staff understood the evacuation process and described in detail how they would evacuate the building depending on the location of the fire.

A fire procedures file was in place which included a plan of the building and a log of when fire training had been delivered. We saw this was completed every quarter with staff. A fire risk assessment was in place and was reviewed every six months and a new assessment put in place. This included information on areas of the service which were not in use and had been locked for people's safety and security. Each locked space had a risk assessment in place for the security and maintenance of vacant spaces in the building, identifying that it not in use. This was also evident on the plan of the building.

An emergency arrangements record was in place which included contact numbers for any failure of utilities or leaks. There was an out of hours number for repairs and maintenance as well as a service continuity plan which included building evacuation, staff absences, and a list of key people to contact.

There was regular testing of the fire alarm system and emergency lighting as well as annual portable appliance testing (PAT).

A health and safety self-inspection checklist was completed quarterly which included checks of the electrical test certificate, gas safety, Lifting Operations Lifting Equipment Regulations 1998 (LOLER) certificates, policy and procedures, training, clinical waste, moving and handling, stress, lighting, ventilation and windows. This also included personal protective equipment (PPE), display screen equipment (DSE), water and temperatures, kitchen safety,

Good

Is the service safe?

the exterior of the building. Any issues were recorded with comments and actions. We saw that some issues had been identified with glazing and redecoration and action had been taken to report the required repairs or to note that the repairs were part of a planned maintenance programme.

Relevant health and safety risk assessments were in place and reviewed on an annual basis.

Staff told us they thought there were enough staff to meet people's needs. The registered manager told us, "During the day there are three care staff and a senior on duty. At night there are two night staff and a senior on call." They added, "We have a cook and two domestics until 3pm and then one domestic." We asked how the staffing levels were calculated. The registered manager said, "I use care plans and risk assessments to check the staffing levels to people's needs. I would bring someone else in if needed, no hesitation." They added, "There's enough staff to meet people needs."

The registered manager explained there had not been any recent recruitment as the staff team were very stable and had worked together for a long time. There had been recent redeployment of some staff from Connolly House due to the numbers of people supported decreasing. This had been managed positively and the staff who remained, wanted to continue to work there. We did see that all staff had renewed DBS certificates in place and there was a record of an appropriate recruitment procedure which included an application process and the successful receipt of references before someone started their employment.

We observed a senior care staff member completing the administration of medicine. All medicine was stored in a locked room, either in a locked trolley or fridge. Temperature checks of the fridge and the room were recorded twice daily. We saw there was a range of information on medicines on display in the medicine room.

The senior care staff washed their hands and explained that the seniors complete a weekly audit of as and when required medicine. This included a stock check and a check of use by dates. This also acted as a prompt for staff to liaise with a person's named doctor if they had been prescribed an 'as and when required' medicine but it hadn't been used for a while. The senior explained that, "It may be that they no longer need the medicine so it can be stopped. Of course if they needed it in the future we would contact the doctor straight away."

The senior care staff member was able to describe people's preferences for how they took their medicine, including information on the use of thickeners and diet fortification.

We saw a biodose system was used and each medicine pod contained the person's name and photograph for identification purposes. Medicine administration records also contained the persons photograph, their date of birth, any known allergies and contact details for their doctor.

The medicine administration record (MAR) was checked against each pod of medicine. The individual pod was taken to the person with their preferred drink and the staff member spent time with the person whilst they took their medicine. Only after the person had taken their medicine was it signed for to say it had been taken. MARs included received by and checked by information which was fully complete and we did not see any evidence of gaps in the recording of the administration of medicines. All liquid medicines had a when opened date recorded on them.

The senior staff member said, "I've done my NVQ 3 and 4 as well as in house training. [The manager] observes us and does a competency check and we have an annual review of competency with the pharmacy."

We saw care plans and risk assessments were in place for medicine administration. One person's stated that the person lacked capacity and referred to the best interest decision and DoLS authorisation. It recorded the person's preference was to have their medicine at mealtimes with a glass of water. A risk assessment was in place which included the risks of non-compliance with medicine and the risk of side effects. We saw a medicine usage and side effect sheet was in the persons file and there was a record of the purpose of the medicine.

Risk assessments were in place for as and when required medicine which included information that night staff would administer this medicine by following the medicine care plan and MAR chart. The senior care staff confirmed that they were on call overnight should night staff need any support around the administration of as and when required medicines.

We saw that people's medicine was reviewed annually by the GP and the pharmacist.

Good

Is the service effective?

Our findings

The staff told us they were well supported by the registered manager and the senior care staff. The registered manager said, "Staff are really supportive of one another."

One staff member said, "The senior staff are helpful and supportive, I have supervisions and get the minutes. They always ask if I'm happy or if there are any courses I want to go on." They added, "We help each other, we are a good working team." Another staff member said, "We all work together, all help out where we can."

We saw a comprehensive staff training matrix was on display on the office wall which showed the refresher periods for training, the training completed and confirmation of training booked. All mandatory training had been completed appropriately.

One staff member said, "I've done dementia training and reminiscence, it's about person centred care, looking for reasons for people's behaviour, looking at their history." Another staff member said, "I've done mental capacity, NVQs, first aid, food hygiene, safeguarding, fire training." They added, "I do moving and handling every year." "I've also done COSHH [control of substances hazardous to health] and food first; we support lots of people with fortified fluids so we need to know about it. I also learnt about gluten free diets and food allergies."

Supervisions were held every two months and a log of who was responsible for supervisions and when they had been held was on display in the office. One senior care staff member said, "We did a three day supervision training course so we know how to supervise staff." We saw that training and development was discussed in each supervision, as were the people supported and their care plans, any operational developments, equality and diversity, work performance and any future targets staff may have.

Appraisal meetings were held annually during November so training needs could be identified and requests sent to the training team in good time for future planning and delivery.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. There was information in the beginning of people's care records to indicate if there was an authorised deprivation of liberty safeguard (DoLS) in place, when it had been granted and when it expired. We saw that appropriate authorisations were in place for people who had been assessed as lacking capacity.

There was information readily available on the multi-agency approached to MCA and DoLS as well as information on independent mental capacity advocates (IMCA) and guidance notes for relevant people.

The service had received praise from an independent assessor with regard for, 'the way files were set out with accurate and updated care plans and risk assessments which reflect the needs of residents.'

People who had do not attempt pulmonary cardiovascular resuscitation orders (DNACPR) in place had been reviewed regularly by the GP and people's next of kin had been involved in the decision making.

One person had a care plan in place for mental health and cognition which included that a DoLS authorisation was in place. It described how staff should reassure the person if they were distressed, such as by 'spending time talking and giving time to express their feelings.' Specific strategies were recorded for staff to follow if the person was distressed such as, 'stay calm, approach calmly and quietly, support other people to move, talk and listen, offer a cup of tea, talk about their family, ask them to help you do something, stay with them until they are calm.'

Staff told us people didn't present with behaviour that challenged, but where behaviour teams had previously been involved with people they kept the care plans and information on record so staff knew what any potential triggers were and how to manage any incidents should they arise.

We saw a care plan and risk assessment was in place for one person who may become agitated. This identified triggers for the agitation and explained how the person may behave if they were becoming agitated, such as leaving the room. There was specific guidance in place for staff to follow to prevent agitation and to manage it should the person become agitated. We observed that staff were very much aware of this persons needs and responded quickly and appropriately to their communication needs.

All staff had been trained in malnutrition and the use of malnutrition universal scoring tool (MUST). The team had

received high praise from the nutrition and dietetics department in relation to a 'food first expectation assessment.' This had assessed the service as meeting all expectations in relation to the use of the MUST tool; the management of malnutrition depending on risk, provision of a fortified diet as part of specific dietary requirements; good communication between kitchen and care staff and having nutrition champions.

The registered manager said, "Staff sit with people and they eat lunch together. It's in peoples care plans as they can role model and it encourages people to eat." They added, "Everything goes at the clients pace."

We observed lunch time and saw that staff supported people in a compassionate and caring manner; they were available to support people on a one to one basis if it was needed, whilst other people ate independently. People were given the time they needed to enjoy a meal and it was a sociable occasion. We saw that all the food available had been freshly prepared and people's specific dietary needs had been met.

A two week menu was on display which included two choices of the main meals. The chef said, "We know what people like, so I will freeze some things so people have a third choice if they want it." The tables were set nicely with table cloths and napkins and people were offered plenty to drink before, during and after their meals.

We saw that one person had speech and language therapy (SALT) recommendations included in their care plans. This included instructions on the person's seating position, that there should be no 'mixed consistency' of foods and there was a list of foods to avoid. This went on to instruct staff that the person needed a 'fork mashable' diet and to have the crusts cut off bread. The person's likes and dislikes were recorded such as, liking to wear an apron and to have a medium sized meal. We asked staff about people's dietary needs and they were able to tell us what each person needed and liked. Staff were able to explain that this person had a coughing monitoring chart and through analysing this information it had been identified that corned beef was a trigger so, with input from SALT, the person was no longer offered corned beef due to the risks.

One staff member said, "The cook knows the residents inside out." They added, "There's plenty of information available, there's soft diet information on the inside of the cupboard door. People can't see it but it's there as a reminder if we need it." Another staff member said, "If the menu doesn't suit someone an alternative's offered."

We saw that the service had achieved an oral health quality assurance award and all staff had been trained in oral care.

People had access to dentists, chiropody and district nurses as needed. It was recorded when people had seen health care professionals and the reason why. We also saw specific notes were kept on GP visits, district nurse visits, hospital attendance/admission, opticians, dentists, chiropody and other professionals.

Six people had emergency health care plans which had been produced by the person's general practitioner. The staff stated they had positive relationships with district nurses and GPs as people tended to have their own designated GP.

Hospital grab packs were in place for people which included vital information that would be useful for healthcare professionals to know about the person. This included their date of birth and GP as well as a photograph, and any known allergies. The person's medical history and an assessment of the person's mobility, nutritional and eating needs and any possible risk factors were also included.

Good

Is the service caring?

Our findings

One relative said, “Staff are second to none – excellent.” Other comments included, “Staff are amazing, everyone works together.” “Staff won’t walk past anyone without stopping to say hello or sitting with people.”

One person said, “I couldn’t do without her” as they pointed to a member of staff smiling. Another person said, “I’m singing in the rain. I’m just having a bit of a joke with the staff. They’re lovely they are.”

One staff member said, “It’s about finding out about people’s past and talking with them about it, did you know [person’s name] can read and spell better than me!” They added, “So we spend time asking how you spell things and doing some writing.” Another staff member said, “I love my job, I’m always learning, there’s great job satisfaction. I make people as happy as I can do, try to keep their minds going.”

The registered manager said, “The compassion of staff is upmost, it’s a homely, stimulating environment. We respect people and their dignity.” They added, “It’s about caring for people, you can’t train compassion it’s felt and staff have it in abundance.”

Another staff member said, “Seeing the smiles on people’s faces are worth more than anything.”

We saw people had memory books which people, their families and the staff had contributed to. These contained precious memories and photographs of people, telling the story of people’s lives, loves and achievements. They were incredibly personal and heart-warming giving a true picture of the person and their history. These life stories were used with people to promote reminiscence and engage with people about the things that were important to them.

The registered manager told me one to one meetings were held with people where they were involved in decision making and planning. Feedback from people and their families was encouraged.

The registered manager explained that people did not have advocates as everyone had family involvement. We saw that information was available for people though should they need it.

There was information around the service on the privacy and dignity policy for people to read and staff told us how important it was that they maintained people’s independence and respected their rights to privacy and dignity. One staff member said, “It’s very important to person centred care.”

We observed that staff were very respectful in their engagements and actively included people in all conversations. Staff were very compassionate and discrete when supporting people with personal care, often saying “Let’s just pop to your room [name of person].”

We saw people were supported to maintain their religious and cultural beliefs. As well as there being a church service at the home once a month we saw care plans were in place for supporting people to attend the church of their choice.

Good

Is the service responsive?

Our findings

People's care records each had a photograph of the person and a photograph of their key worker. A key worker is the main staff member responsible for the persons care.

General information was in the beginning of people's files which included information on the persons GP, next of kin, and preferred language and funeral arrangements. People had personal profiles which included their place of birth, family history and connections and their likes and dislikes.

Each person had a full index of care plans which were in place dependant on their assessed needs. The numbers of staff needed to support people with specific tasks such as using a stand aid hoist for all transfers was well documented. There was information on communication, sensory needs, continence, medical history, medicine, mental health, diet and nutrition, skin integrity, social activities, personal safety and ability to assess risk and financial management.

We saw that people's care records were regularly reviewed and updated according to any change in their needs or circumstances. The registered manager also ensured an annual review was held with the person's social worker or care manager.

People had plans of care for personal care and physical well-being. One person's plan included information on their preference for a shower during the early evening. It specified the time the person liked to get up and retire to bed. It also specified how many staff were needed to support and to 'give time and space to choose own clothes.' The outcome was to 'retain and promote existing skills, maintain dignity, be diplomatic and tactful.' There was a statement to say a best interest decision was in place for consent to care.

This person's communication needs were well understood and stated their communication was, 'non-verbal through facial expressions and body language, can respond to short questions.' Staff should, 'give time and space [for the person] to think about and respond.' It also stated that the person may not respond but staff were to continue to involve the person in communication and engagement.

A care plan for one person's mobility gave background information that the person was no longer able to mobilise safely but could weight bear. This stated that the person had received occupational therapy input with regard to the use of a hoist. There was specific information in relation to the hoist and sling to be used and how staff should support the person. The care plan instructed staff to inform the person what was happening at each stage of the transfer and to check all equipment on a daily basis. We observed the staff following this support plan in a sensitive and respectful manner explaining to the person what was happening and offering appropriate reassurance. There was an associated risk assessment in relation to mobility.

One person's personal profile included likes and dislikes. It stated, '[the person] doesn't like sudden changes in daily routine and gets agitated if things aren't how they should be.'

Records included areas where the person was independent, whether they needed prompts, required assistance or needed the full support of staff. There was detail on the number of staff needed for specific tasks.

The specific bathroom this person preferred to have a shower in was recorded, along with the day and time they preferred. We observed staff were very aware of this person's need to follow a daily routine and were very conscious and respectful of this in all their engagement with the person.

The activities people enjoyed were recorded in their care records such as, 'walks, shops, sensory doll, family time.' We saw many photographs of activities displayed around the service as well as albums of photographs from events.

An activities board was on display which included board games, books, videos, music, dancing, exercise, ballgames, colouring, art and crafts, puzzles, reminiscence and gardening. We saw that one person grew tomato plants and this had been documented in a series of photographs.

There was a well-equipped sensory room at Connolly House which was used by people. The registered manager said, "If staff need to have five minutes because of an incident or something difficult I often tell them to have time in the sensory room to relax and take a break." We also saw there was a cinema room for people to use.

'Pet therapy' visited the service every two weeks and people knew the visiting dog well and enjoyed the stimulation it offered.

We observed a shopping reminiscence event and saw staff using shopping items and their knowledge of the person to

Good

Is the service responsive?

evoke memories. We saw how some spaghetti led to a conversation with one person about their Italian heritage; this led to the singing of songs and triggered memories for other people about time spent abroad.

A comments, suggestions and complaints policy was in place as was a log of complaints received. The log included the date the complaint was received and the name of the complainant, the nature of the complaint and who received it. There was reference to the completion of a complaints form, who was investigating and the outcome.

The registered manager said, "I would try to deal with it in house first informally or contact the complaints and compliments officer. If the complaint was about me I'd direct the person to the appropriate person to hear their concern."

When we asked about how people and their families were encouraged to provide feedback the registered manager said, "We have one to one meetings with residents and families and we have a comments book for relatives to write in. If someone had a concern I think they would just say it, we have really good relationships with families."

We saw the comments book included comments like, 'thank you for the kindness and love and care'. 'There's a box of chocolate for staff "heroes" as they are all heroes.' And 'I cannot thank you enough.'

Good

Is the service well-led?

Our findings

One senior care staff member said, “Staff are really positive, supportive of colleagues and managers.” They added, “We’ve broken down the barriers of cook, domestic, care staff. Everyone has the same level of training and has something equally valuable to offer.”

One staff member said, “The managers and seniors are very transparent and supportive.”

One staff member described the culture as, “A caring, learning culture.” They added, “Staff thrive to give their best. It’s a relaxed and caring atmosphere, staff want to be here. They aren’t scared to ask questions or challenge professionals.” Another staff member said, “We just want the best for people.”

A senior staff member said, “Staff will say if they don’t know something but will also find things out. They take on board what people and family members say to us, it’s a positive team.”

There were regular staff meetings which were attended by care staff, ancillary staff and the senior care staff and registered manager. The agenda included health and safety, safeguarding, infection control, dementia care and the principles of care including dignity and privacy as well as the CQC standards. There was also time given to sharing information about the people they supported and any concerns could be shared and discussed in an open and transparent manner.

Separate senior care staff meetings were held which included discussions on their responsibilities such as supervision and going through checks to ensure all care plans, risk assessments were updated and reviewed on a monthly basis.

The registered manager said senior managers were supportive and they had monthly supervision with their manager who also visited the service on a monthly basis and completed a quality assurance visit.

When asked about quality assurance audits the registered manager said, “I do monthly medicine audits, care plans and accidents and falls audits. Three monthly health and safety inspections and fire procedure updates as well as the training and performance management audit. Six monthly it’s the fire safety risk assessment, full quality assurance and lifting equipment. Then annually it’s risk assessment, a COSHH risk assessment audit, infection control, training, holidays and equipment calibration.”

The six monthly quality assurance checklist included care records; the environment, activities, complaints; health and safety; staff interaction; and management and administration. We saw that were actions had been identified these had been recorded and completed.

Care plan audits were completed monthly. They included assurances around people’s involvement in their care plans, an audit of DNACPRs, DoLS, best interest decisions, support plans, person centred care and risk assessments, personal emergency evacuation plans and involvement from others. Each audit had space for comments and action plans. Comments included the need for a social worker to complete an annual review. The action recorded was the date the social worker had been informed and we saw on the next month’s audit the annual review had taken place.

Medicine audits were completed on a monthly basis. This included a check of the medicine administration record and a stock check. We also saw that the audit included the date of staff observations and competency checks and when these were next due to be completed, for example on a six monthly basis. The checks included the record of allergies, doctor, double signatures on hand written MARS and the returns book.

An annual training audit was completed by the registered manager. They explained that the employee performance management meetings (supervisions) identified training needs via constant monitoring. They then completed an audit which included ensuring any booked training was written in the diary. Once this had been attended it was ticked off on the audit to say it had been completed by the staff member. If they hadn’t attended the reason why would be recorded and the training re-booked. This was audited on a monthly basis.

A fire procedures audit was completed which included action that staff needed to read and sign the night time procedures and that a fire drill needed to be held.

A senior manager also completed quarterly visit reports which included complaints, safeguarding, reviews, CQC notifications and a review of security procedures. It also included an audit of staffing, training and supervisions

Good

Is the service well-led?

issues. This included information that families and staff were anxious about the future of the home due to proposed changes. The registered manager explained that they were being as transparent as they could be with everyone and had regular opportunities for people to share their thoughts and concerns but at the minute were unable to provide any definitive answers or plans for the future.

An improvement plan was in place which included detail on the aim, objective, the responsible person and a target date. This included action around ensuring supervisions and training were provided appropriately; monitoring the environment and ensuring all peoples care records were kept up to date.

Staff signature sheets were in place for staff to sign to say they had read people's care plans and risk assessments.

We saw a written handover book was in place and observed that handovers took place between seniors at every shift change. Information was then cascaded to the care staff by the senior.

When asked about handovers a senior care staff member said, "We read all the notes in the care plans and pass information over to the care staff. Information's also recorded in the handover book. The domestics and the cook are included in the handover as well in case there are things they need to know." They added, "We also have a communication book that's to be signed to say that information has been cascaded."

Relative satisfaction surveys were given out every six months. We saw that in March 2015 six responses had been received with all comments being that people were satisfied with the service provided by Connolly House. There was no action to be taken. Relatives were directed to give comment on the environment, the staffing, any improvements they thought were needed, the therapeutic input people received, activities being offered, meal, choice and the overall quality of the service. Comments were very positive and praised the staff team for being caring.

When asked about staff surveys we were told by one staff member, "We don't need them, if we have any concerns we raise them in the team meeting, supervision or just ask for a chat."