The Royal Masonic Benevolent Institution Care Company

Connaught Court

Inspection report

Connaught Court
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Ratings

Overall rating for this service	Good

Is the service safe?	
Is the service well-led?	

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Connaught Court on 25 May 2018. The inspection was prompted by the death of a person who used the service who had left the service and had fallen.

We inspected the service against two of the five questions we ask about services: is the service safe and is the service well led? No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Connaught Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Connaught Court accommodates up to 90 people across six separate units, each of which have separate adapted facilities. At the time of our inspection one of the units was closed for some renovation work. There were a total of 82 people living at the service. Two of the units specialised in providing care to people living with dementia.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The CQC had been notified about two police incidents. These involved the police being contacted in respect of two people who had left the service unobserved on two separate occasions. Actions to reduce the risks related to these incidents had been taken immediately to ensure the risks were managed as effectively as possible.

One person whose behaviour posed a risk of harm to themselves and others did not have a risk assessment in respect of this. This was completed during our inspection. Two incidents of distress which could have caused harm to others had not been handed over to the senior staff team. This meant they were unable to take the action required to mitigate the risks to the person and others.

Overall risks to people living at the service were assessed and measures to reduce risks were put in place. We saw that risk assessments and mental capacity assessments in respect of people's ability to independently access the community were being completed.

There were sufficient staff to meet people's needs. In the main we saw a relaxed environment with people being supported by staff in an unrushed manner. However, prior to the lunch time meal call bells sounded

repeatedly on the general residential unit. The registered manager agreed to review the deployment of staff before, during and after meal times.

Staff were safely recruited and a senior member of staff had recently been employed for two days per week as a 'medicines champion.'

There were a range of systems in place at a management and provider level to assess and monitor the quality of service being provided to people living at Connaught Court.

People, relatives and the staff team were given opportunities to comment on the running of the service. They told us the management team were supportive.

Care records were electronic and they were stored securely. In the main CQC notifications were made appropriately by the management team. However, the CQC had not been notified about a specific incident. We asked for a retrospective notification once we had been alerted to the incident which was received. This is being looked at outside of the inspection process.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were sufficient staff available to meet people's needs. The registered manager agreed to review the deployment of staff before, during and after meals.

Overall risks to people living at the service were assessed and measures to reduce identified risks were in place.

Incidents were reviewed to ensure action to keep people safe was taken. However, we identified two incidents which had not been appropriately handed over to the senior team.

Is the service well-led?

Good

The service was well led.

People who lived at the service, their relatives and the staff team had the opportunity to provide feedback about the quality of care provided.

The management team and the provider had well developed systems in place to assess, review and improve the quality of care being provided.

There was a transparent culture within the management team.

Care Quality Commission

Connaught 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 25 May 2018 and was unannounced.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. We are assisting the Coroner with this matter. The local authority is also involved and they are conducting their own investigations under their safeguarding procedures. The information shared with CQC about the incident indicated potential concerns about the management of risks related to people leaving the service without support. This inspection examined those risks and was completed by one inspector.

Before this inspection we reviewed the information we held about the service, such as information we had received from the local authority, and notifications we had received from the provider. Notifications are documents that the provider submits to the CQC to inform us of important events that happen in the service. We used information the provider sent to us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with the registered manager, the deputy manager, a team leader and two members of care staff. We spoke with two people who lived at the home. We looked at two people's care and support plans and a range of associated risk assessments. We reviewed documents and records that related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We reviewed the notifications we had received from the service since the last inspection. Two of these were about police incidents. These separate incidents related to the police being called following people who lived at the service who had left the building and going missing from the service. We reviewed these incidents during the inspection and found neither person had been harmed. One person was found in the grounds, which are extensive. However, another person had managed to get into York city centre.

Following the incidents immediate action had been taken to ensure the persons were safe and they were both seen by a medical professional. One person was moved from the general residential unit to the dementia residential unit once a room became available for them. Following this incident the Home started to implement the "Herbert Protocol" which is an initiative launched by York Police.

The service had already applied for a Deprivation of Liberty Safeguard (DoLS) and in light of the concern they asked the authorising authority to authorise an urgent DoLS. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

To reduce the risks associated with people leaving the unit additional door sensors had been fitted to alert staff should someone attempt to leave. The service had applied for a DoLS for this person but at the time of the incident this had not been authorised. They did not request a more urgent assessment. We discussed this with the registered manager who agreed this is something they would consider doing should any incidents re-occur.

The registered manager explained that neither of the incidents had been referred to the local safeguarding authority as they were stand-alone incidents and the person had not come to harm. They had taken the required measures to keep people safe. We checked with the local safeguarding authority who confirmed they were satisfied these incidents did not need to be referred to them for investigation.

With regard to safety overall, risk assessments were in place, along with measures to reduce the risk of harm. For example, risk assessments associated with the use of bed safety rails, falls and skin integrity were detailed. Despite this, we identified one person who posed a risk to themselves or others due to their mental health, which had not been effectively risk assessed. There were incidents within the person's progress notes which showed they had been verbally aggressive and had attempted to hit staff members due to their distress. Although the person was being supported by the community mental health team there was no guidance for staff about how to reduce the risk of harm to the person or those around them.

We discussed this with the team leader on the unit who informed us they would complete a risk assessment immediately. When we spoke with the registered manager about this they confirmed this was now in place along with an ABC chart. An ABC chart is used to record behaviours which pose a risk of harm to the person or others. It records specific incidents to enable staff and supporting professionals to analysis incidents such

as any triggers.

The team leader on the residential unit explained they were in the process of completing a risk assessment and mental capacity assessment for everyone who went out of the home alone. We discussed this with the registered manager as not everyone would require this. Mental Capacity assessments and risk assessments should only be completed where there is a specific concern about a person's ability to understand the risks of leaving the service. They should not be completed as a blanket response. For example, we heard some people living at the service were very independent. One person drove abroad on regular holidays and did not require support.

We discussed this with the registered manager as not everyone would require this, they agreed and demonstrated a sound understanding of the Mental Capacity Act. They confirmed people who used the service are assumed to have the ability to make their own decisions unless proven otherwise. This showed they adhered to the principles of the legislation. They agreed to discuss this matter with the unit lead and team leader.

There were systems in place to review accidents and incidents. However, we identified two incidents which should have been reported to the management team. Incident forms had not been completed and the information had not been passed on via the staff handover. The handover is an opportunity for staff to share any specific information or concerns about people living at the service. The registered manager told us they would investigate why these incidents had not been appropriately passed on and complete any additional re training which may be required.

Following the inspection we spoke with the registered manager who explained the assistant manager, responsible for leadership and oversight on the residential unit, would be attending the morning handover to 'spot check' the quality of these and to ensure staff understood the need for key information to be passed on.

The service had recently appointed a senior care worker into the role of 'medication champion.' This meant the staff member had two days per week to focus on everything related to medicines. There were robust audits in place to ensure that people were receiving their medicines safely and that the systems in place around medicines management were operating to a high standard. These had been completed weekly by the deputy manager but they were in the process of handing this work over to the medication champion who had been employed specifically to lead this.

Overall the service had sufficient staff to meet people's needs. We received mixed feedback from staff about staffing levels. Comments included, "Staff feel under pressure but none of the residents have ever complained. We prioritise people's needs" "We do well, our residents have nothing but praise for us" "We have enough staff to meet people's needs" and "Some days there are plenty of staff and on other days we are stretched." They explained this depended on what was going on in the service, for example if a lot of people had medical appointments on the same day. A person living at the service said, "In the main staff come quickly enough. I had a fall they [staff] were here immediately and were very effective when they got here."

Generally the environment was relaxed and people enjoyed interaction with staff which was unrushed. However, whilst we were reviewing care records on the residential unit we heard call bells were ringing repeatedly from 12.30 for approximately thirty minutes. We saw staff responded to these requests but it was a very busy period of time. We discussed this with the registered manager. They explained this was often a busy time as people were being supported to go downstairs to the main restaurant area for their lunch. They

agreed to review the deployment of staff before, during and after meal times.

Staff had been recruited safely. People had completed application forms; two references had been sought and a Disclosure and Barring Service (DBS) check carried out. DBS checks provide information about any convictions, cautions, warnings or reprimands and also lists if people are barred from working with adults requiring support or children. These checks help employers make safer recruitment decisions and are designed to minimise the risk of unsuitable people working in health or social care settings.

Good

Is the service well-led?

Our findings

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported by a management team which included an assistant manager, deputy manager and team leaders.

One person living at the service told us, "The staff are very attentive. I can be independent but they keep a watch on me." They described feeling respected and valued by the staff team. A member of staff told us, "People respect and listen to each other; the management team listen to you. People living here have a good life. If my relative needed 24-hour care I would like them to live here."

Each morning there was a meeting called an '11 at 11' these involved managers from all departments meeting to discuss a range of topics which included any significant incidents, people who were new to the service and any events planned for that day. The registered manager explained that staff enjoyed this and it helped them to understand what was happening within different departments and was part of a, "whole team approach to providing a high standard of care."

The deputy manager explained feedback was sought from people living at the service, their relatives, staff and supporting professionals in a variety of ways. They explained the management team operated an open-door policy, annual surveys were completed along with residents and relatives meetings which were known as a 'cheese and wine nights'.

The service has recently developed a staff forum to support staff to raise any areas of concern they may have. Staff described feeling well supported by the management team and felt able to raise any concerns they may have.

There were systems in place to improve the quality of the service and safety for people living there. The management team completed a range of audits which included medicines, care plans, infection control and health and safety. The service had a continuous improvement plan. Any actions identified were cross referenced and added to the plan. This meant there was a clear record of areas for ongoing improvement and the work which was being completed to address this.

Care records were completed electronically and stored securely to ensure confidentiality was protected. Accidents and incident forms were reviewed by the registered manager and then sent to the provider for additional oversight. Monthly analysis of accidents/ incidents had been carried out by the management team, this was to monitor and identify any trends and patterns. This meant there were systems in place to ensure that actions were taken to reduce known risks to people.

The registered manager explained there had been some work undertaken to review falls. An analysis of falls had identified that there was an increased risk of people falling on a Saturday afternoon. Following this the

operations manager came in and completed some 'spot checks' on a Saturday afternoon to ensure people were being supported appropriately. The incidents of falls had subsequently reduced. This demonstrated a commitment to ongoing service improvement.

The registered manager described feeling well supported by the provider. They explained their regional manager visited the service every six weeks and completed a range of quality assurance checks. For example, they reviewed care planning records, completed spot checks on people's bedrooms to ensure they are clean and homely, talked with people and staff and reviewed the continuous improvement plan.

The provider's health and safety team completed an independent health and safety audit every three months. A compliance auditor visited every three months, this was unannounced, and they reviewed the service in line with the CQCs key lines of enquiry with the aim of supporting the service to deliver a high standard of care. An internal audit had been completed in February 2018 and had rated the service as 'Good', with some improvement actions added to the continuous improvement plan. We saw evidence that some of these had been rectified.

Overall notifications were made appropriately and the registered manager understood their role and responsibilities well. However, the CQC had not been notified about a specific incident. We asked for a retrospective notification once we had been alerted to the incident which was received. This is being looked at outside of the inspection process.

The registered manager was open and transparent throughout the inspection visit. Following our feedback, the registered manager contacted the CQC to provide an update on the actions they had taken in respect of the points we raised. They advised they had arranged a supervision and additional training for the staff members involved who had failed to adhere to the policies in place in respect of passing information onto the senior staff team. This demonstrated a commitment to acting on feedback and improving the service.