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?	Good
Is the service effective?	Outstanding ☆
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 28 March 2017 and was unannounced. This is the first inspection since the home was registered under a different legal entity in March 2016.

The home is registered to provide residential and nursing care for up to 90 older people, including people who are living with dementia. On the day of the inspection there were 85 people living at the home, including two people who were receiving respite care. The home is situated on the outskirts of York. There are six units: Knavesmire, Fred Crossland House, Viking, Fairfax, Yorvik and Ebor. Viking is for people who require nursing care, and Fred Crossland House and Knavesmire are for people who are living with dementia. The other units are for people who require residential care.

Some parts of the premises were on one level and other areas had a lower ground floor and a first floor. The first floor was accessed by a passenger lift.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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 areas of the home specifically designed for people living with dementia provided an exceptional environment that promoted meaningful occupation. This included tactile items, old fashioned furniture and rooms that looked like a living room in a person's own home. This resulted in a calm atmosphere where people were able to live as they chose to live.

We saw that people's nutritional needs had been assessed and individual food and drink requirements were met. People told us that they were very happy with the food provided and we observed that there was ample choice. The dining room was presented in 'hotel' style and people had their own bottles of wine on the table if this was their wish. People socialised with other people and with staff. Staff support in the dementia areas of the home was unobtrusive. People were shown a variety of choices and alternatives were provided if people were not interested in the choices on offer. Staff ate with people in these areas of the home and this produced a calm family atmosphere where people were encouraged to eat and drink.

The home was following a recognised dementia model that incorporated good practice guidance. They were one of the few homes in the country to have achieved awards with the organisation that produced the model.

People were protected from the risk of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood

their responsibilities in respect of protecting people from the risk of harm.

There was evidence that the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

There were recruitment and selection policies in place and these had been followed to ensure that only people considered suitable to work with vulnerable people had been employed. On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs.

Training records showed that staff had completed the training they needed to carry out their roles effectively. Staff told us that they were well supported by the registered manager.

There were appropriate policies and procedures in place on the management of medicines, and senior staff had received appropriate training. We checked medication systems and saw that medicines were stored, recorded and administered safely.

People who lived at the home and relatives told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home and staff, and that staff had a good understanding of people's individual care and support needs.

Care plans included information to guide staff on how to meet people's assessed care and support needs and to understand their individual preferences and personalities, although some information required updating to ensure they included the very latest information.

A wide variety of activities were provided and people were encouraged to take part. This included activities specifically for people who were living with dementia. People told us their family and friends were made welcome at the home.

There were systems in place to seek feedback from people who lived at the home, relatives and staff and there was evidence that people's comments were listened to and acted on.

People told us they were confident their complaints and concerns would be listened to. Complaints received by the registered provider had been investigated and appropriate action taken to make any required improvements.

Quality audits undertaken by the registered manager and others were designed to identify that systems at the home were being followed to ensure people were safe and well cared for.

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 had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse.

Staff had been recruited following the home's policies and procedures and there were sufficient numbers of staff employed to ensure people received safe and effective support.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Is the service effective?

Outstanding

The service was very effective.

The premises had been designed and equipped in a way that enhanced the lives of people who were living with dementia.

Staff undertook training, including experiential learning, that gave them the skills and knowledge required to carry out their roles. Some staff had completed specific training on working with people who were living with dementia, with effective results.

We saw that a variety of meals were prepared to meet people's individual dietary requirements. Different dining styles were promoted for people with differing needs and this meant that everyone who lived at the home had a positive dining experience.

The principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. People's health care needs had been well met.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at

the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

We saw that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their support needs and how these should be met by staff, although some required updating. Care provided was person-centred.

A wide variety of activities were provided and visitors were made welcome at the home.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to. People were encouraged to give feedback about the service they received.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post. They had submitted notifications as required by legislation.

Staff told us that they were well supported by the registered manager and senior managers within the organisation.

Audits were being carried out to monitor the effectiveness of the service.

There were opportunities for staff and other people involved in a person's care to give feedback about the service provided.

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 checked whether the registered 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.

The inspection took place on 28 March 2017 and was unannounced. The inspection was carried out by three adult social care (ASC) inspectors and an expert-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.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the CQC to inform us of important events that happen in the service. The registered provider was not asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with 11 people who lived at the home, two relatives / visitors, six members of staff, the deputy manager and the registered manager. We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for six people who lived at the home, the recruitment and training records for four members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

People told us that they felt safe living at the home. One person told us, "I feel very safe but not over supervised as the support of the staff is not obtrusive." A visitor said, "[Name of person living at the home] needs to be here and they keep them safe." Staff told us they kept people safe by making sure equipment was well maintained and was used in accordance with safety requirements, by administering medication following the home's policies and procedures and by having risk assessments in place.

Risk assessments had been completed to advise staff how to manage any identified risks. This included risk assessments for falls. We found that falls risk assessments did not always make clear what control measures were in place and what action had been taken to minimise the risk. However, some information was included in a 'falls' tracker that was updated each month; analysis took place and an action plan was produced.

We observed that staff used the correct equipment and used safe moving and handling techniques when assisting people to mobilise. When needed, people had been provided with equipment such as pressure relieving mattresses to reduce the risk of them developing pressure sores.

Staff, including ancillary staff, had received training on safeguarding adults from abuse. Staff who we spoke with were able to describe different types of abuse they may become aware of and the action they would take to protect people from harm. Staff told us they would not hesitate to use the home's whistle blowing policy. The local authority safeguarding team told us they had received nine concerns about people living at the home in 2016, but none had progressed to an enquiry. We looked at the safeguarding records held in the home and these evidenced that any issues had been appropriately managed.

The registered manager told us they used a dependency tool to determine staffing levels. They explained the staffing levels for each area of the home. In the nursing area there was a registered nurse plus three care workers on duty throughout the day. Other areas of the home were staffed by a combination of shift leaders, senior care workers and care workers. People who lived at the home told us there were enough members of staff on duty. One person said, "Yes, this place is very generously staffed. I don't know how they do it." We observed that there were sufficient numbers of staff on duty to meet people's individual needs, including in the areas of the home where people were living with dementia, and that call bells were responded to promptly.

There were two activities coordinators employed at the home, and numerous ancillary staff such as a receptionist, cooks, kitchen assistants, domestic assistants, laundry assistants and maintenance staff. This meant that care staff were able to concentrate on meeting people's care and support needs.

We checked the recruitment records for four members of staff. These records evidenced that references and a Disclosure and Barring Service (DBS) check were in place prior to people commencing work. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from

working with children and adults. Checks had also been made to make sure people had a legal right to work in this country. These checks meant that only staff considered safe to work with people who may be vulnerable had been employed by the service.

We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately. There were comprehensive medicines policies and procedures in place to guide staff on the safe management of medicines, including homely remedies, auditing, self-administration and covert administration. These were based on good practice guidance from the Nursing and Midwifery Council (NMC), the Royal Pharmaceutical Society of Great Britain and the National Institute for Care and Health Excellence (NICE).

Medication administration records (MARs) were managed electronically. People had a medicine cabinet in their own room and the nurse or senior staff member took the laptop to their room and recorded when medicines had been administered. There was also a record of when 'as and when required' (PRN) medicines had been administered, and the reason why. Controlled drugs (CDs) were recorded both electronically and in a separate CD register. CDs are medicines that require specific storage and recording arrangements. When any changes were made to prescribed medicines, the person's GP signed the printed MAR chart to evidence this.

Nurses and senior staff had completed training on the administration of medicines although this information was not recorded on the training matrix. Senior staff who we spoke with confirmed they had training on the management of medicines each year, both from the pharmacy used by the home and as a distance learning course. Staff told us that they also had medicines competency checks.

Accidents and incidents were recorded and analysed each month to identify any possible contributory factors and any improvements that needed to be made. The analysis included information about any falls or missed medication, and was forwarded to the organisations head office each month for further analysis.

There was a contingency plan that provided advice for staff on how to deal with unexpected emergencies, and each person had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to evacuate the premises. A 'disaster' box contained torches, a first aid box, emergency blankets and fire safety documents. These included plans of the premises and a detailed list of everyone who lived at the home. Fire drills were undertaken during the night to ensure staff knew how to evacuate the premises in an emergency.

People told us the home was clean and hygienic and we observed this on the day of the inspection. The laundry room had a 'dirty to clean' flow and was easy to keep clean. An infection control audit had been carried out, staff were provided with ample personal protective equipment (PPE) and 'hand wash' facilities were sited around the home.

We reviewed service certificates and these evidenced that equipment and systems had been appropriately maintained. This included the fire alarm, passenger lifts, mobility and bath hoists, portable electrical appliances and gas safety. We did not see the home's electrical installation certificate but there was a record of the date the most recent check had been carried out. A home safety inspection was carried out that looked at maintenance, environmental risk assessments, accident reporting, moving and handling and first aid. The most recent inspection had been carried out in December 2016 and no issues had been identified. In-house checks of the fire alarm system, emergency lighting and extinguishers were also carried out.

Outstanding ☆

Is the service effective?

Our findings

Staff received induction training when they were new in post. The registered manager told us that people completed a minimum of two days on the induction programme that included the topics of fire safety, health and safety, moving and handling and equality and diversity. Staff had a 'buddy' who supported them when they were new in post, and their buddy completed a report on their progress. People were initially employed as bank staff for a probationary period of six months. The registered manager said they felt this tested staff's commitment to the organisation. If the employee proved to be satisfactory, they had a brief interview and were offered a permanent contract.

If new employees had not already achieved a National Vocational Qualification (NVQ) or equivalent, and when they had completed the home's induction programme, they were enrolled on the Care Certificate. The Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards.

The registered manager told us the training manager was developing 'experiential' learning for care staff, such as them spending time in a wet incontinence pad, in a wheelchair and with an eye patch. This was aimed at enhancing staff understanding of the specific needs of some of the people who lived at the home. Staff were also required to read the 'policy of the month' and sign a document to evidence they had read it. This was to make sure staff were familiar with key policies and procedures in place at the home.

The training matrix showed staff had completed training on the topics considered essential by the registered provider, including fire safety, moving and handling, safeguarding adults from abuse, health and safety, first aid, equality and diversity, food safety and the Mental Capacity Act 2005 (MCA). The training matrix also recorded the frequency this training had to be completed, either yearly or three yearly. There was a system in place to remind people when refresher training was overdue, and the registered manager told us that non-attendance could result in disciplinary action.

Staff told us they felt well supported and that they were listened to. We saw evidence that staff received regular supervision and an annual appraisal. This meant staff had the opportunity to meet with a more senior staff member to discuss any concerns and their development needs.

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). Care plans recorded when people had a DoLS authorisation in place and when these were due for renewal.

Staff, including ancillary staff, had completed training on the MCA. We found staff had a good understanding about people's rights and the importance of obtaining people's consent to their care. A member of staff told us, "We are very good at this home. We follow person-centred care. We don't take control, we ask people" and another one said, "When we help people we tell them what we are doing and ask them throughout."

Staff explained to us how they helped people to make day-to-day decisions, such as showing them meals to help them make a choice and encouraging people to choose what clothes to wear, whilst giving advice about suitable clothes to wear for the weather / season.

People who received nursing care were supported by nurses employed by the service. People in receipt of residential care were supported by community nurses; district nursing notes were kept in people's bedrooms. People told us they had easy access to a GP of their choice. People also had access to other health care professionals such as occupational therapists, physiotherapists, the mental health 'crisis' team and speech and language therapists (SALT). We saw any advice sought from health care professionals had been incorporated into care plans.

It was evident from our observations and from speaking to people that there was a great emphasis on the importance of people eating and drinking well. People told us they liked the meals at the home. One person said, "The food is brilliant. There are choices for all meals and you can choose a fish dish every day if you want to" and another person told us, "The food here is better than good. It is a decent menu and repeats every three weeks." There was a menu on display and people were asked what they would like for lunch the day before; we noted this included whether they would like a small, medium or large portion. We observed the serving of lunch in the main dining room and saw that there were sufficient numbers of staff to provide people with assistance if they required it. Some people had been provided with special cutlery to promote their independence. People sat in the same place each day, and there was a name plate to reserve their place. If they had chosen to have wine with their meal, their named bottle of wine had been placed on the table.

In the dementia areas of the home, people were shown the two choices of meal on the menu at lunchtime. This helped them to make a decision about which meal they would prefer. People were also shown two juices so they could choose by colour rather than having to state 'orange' or 'blackcurrant'. We saw that, if people did not like their meal once they had started to eat it, an alternative was provided. When lunch had been served, a member of staff sat at each table and had their lunch along with people who lived at the home. In this way, care staff were able to provide help and support whilst making the lunchtime a more pleasant and inclusive experience. This also appeared to encourage social interaction between people who lived at the home and improved the wellbeing of people living there.

People's special dietary requirements, likes and dislikes were recorded in their care plan and we saw people had appropriate nutritional assessments and risk assessments in place. We spoke with a cook who told us they had a list of people's special diets in the kitchen, including any known allergies. Special diets included low fibre, vegetarian and diabetic diets, and soya milk and lactose free milk were also provided. The cook said that the budget allocated allowed them to buy good quality products. The cook told us that one cook worked over breakfast and lunchtime, and another cook worked at tea-time and in preparing meals for the next day, so there was never a need for care staff to assist with meal preparation. We saw that snacks and drinks were freely available throughout the home.

The environment for people living with dementia was exceptional. There were different seating areas to suit people's different needs. One area had a fireplace with sofas arranged around it, making it look like a living room in an average house and one person chose to sit in there for most of the day. Another area had French windows that provided a view of the enclosed garden, a vegetable patch and the chicken run. A further area provided a TV room and again, looked like an everyday living room. One person was lying on the settee watching the TV, probably like they would have done in their own home. There were tactile objects to keep people occupied in the lounge areas, in the dining / kitchen area and along all corridors. This included a washing line (with clothes hanging from it), old radios, an old piano, twiddlemuffs, musical instruments, soft

toys, items on dressing tables, a silver cross pram, old food packaging and pictures of film stars.

Although there was some signage to help people to orientate themselves around the home, in many instances items of furniture or furnishings were used to assist people to identify the purpose of the room, rather than them having to interpret a written word or a picture.

The service used a recognised dementia care model produced by Dementia Care Matters and three staff had achieved that organisation's Level 1 award. They told us that only 17 care homes in the country had achieved this. It was clear when we looked around the dementia areas of the home and spoke with staff that the good practice guidance provided in this dementia training had been shared with other staff. Staff were working with people individually or in very small groups and there was a calm, supportive family atmosphere.

Overall, the home was clean, modern and inviting. All garden areas were enclosed so that they provided a safe space for people to spend time. Most corridors were wide and mainly straight, with no obstacles. This made it easy for people to move around if they wished, and gave good lines of sight for the staff to identify if people needed assistance.

Good

Is the service caring?

Our findings

We observed that people were relaxed in the company of staff and that staff were polite, caring and sensitive to people's needs. People who lived at the home told us that they felt staff genuinely cared about them. Comments included, "The staff who look after me are wonderful people", "When I go out they always welcome me back, so I know they are looking out for me" and "The staff couldn't be nicer." A relative told us, "Whenever I have been here, the staff have always been very nice to [Name of person living at the home]."

Staff told us that staff who worked at the home genuinely cared about people who lived there. They said that, if people were not right for the job, this would be picked up during their probationary period and they would not be offered a permanent contract. One member of staff said, "We really care. We are committed to following best practice."

The registered manager told us that everyone who lived at the home received wine, chocolates and a card for their birthday and more gifts when they had a special birthday, for example, 80, 85 or 90 years old.

We noted that observing interaction with people who lived at the home was part of the interview process for new care staff. This showed that the organisation placed emphasis on relationships between people who lived at the home and staff.

People's preferred name was recorded in their care plan and we observed these were being used by staff. Staff explained how they promoted privacy and dignity with people they supported. Comments included, "I wrap people with a towel to keep them warm and protect their modesty" and "We keep all doors shut and curtains closed." We saw that staff knocked on bedroom doors and asked if they could enter. When they assisted people around the home, they chatted to them about their activities or their families. A relative told us, "Staff treat our relative with the utmost dignity."

We noted that, although staff had training on equality and diversity, care plans only included minimal information about equality and diversity. This was acknowledged by the registered manager, who told us the new assessment tool they had introduced would broach these topics with people.

People told us that staff encouraged them to be as independent as possible. One person said, "I am able to do what I want when I want. If I need help with anything, I know I only have to ask." Staff told us they promoted independence and they knew people's routines. One member of staff told us, "We encourage them – we want them to live like they did at home."

The registered manager told us that no-one required the assistance of an Independent Mental Capacity Advocate (IMCA). IMCAs provide support for people who lack the capacity to make their own decisions and have no-one else to represent them. Information about other advocacy services was displayed in the home. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

There was a policy on confidentiality that was shared with all staff. This recorded that all staff had to sign a form to confirm that they understood and accepted the principles of confidentiality. We noted that all information about people who lived at the home, paper and electronic, was stored confidentially.

The home had its own chapel which was non-denominational. One person who lived at the home was a bishop and they conducted a weekly service. A chaplain also visited the home.
The home were able to hold funerals at the chapel, and the registered manager said that meant it was easy for people who lived at the home to attend the funerals of fellow residents, which allowed them to say goodbye.

Care plans recorded when people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) in place. There was no option on the electronic care planning system to produce an end of life care plan and we saw that some people's care plans had not been updated to reflect that they were receiving end of life care. However, the feedback about the care people received at the end of their life was very positive.

Good

Is the service responsive?

Our findings

We saw the new needs assessment tool that was completed when people made enquiries about moving into the home. This was very comprehensive and covered the areas of consent and capacity, communication, support needed with behaviours or distress, mobility, medication and pain control, nutrition / weight, skin integrity, personal hygiene, continence, social activity, orientation and sleep. In addition to this, the assessment included a brief life history and details of people involved in the person's care. Assessment information had been used to develop an individual plan of care; we saw there was a care plan summary and an extended care plan.

Some people told us they had been involved in a review of their care plan and we saw that care plans were reviewed on a regular basis. However, we saw there were some anomalies in care plans. For example, one person's care plan did not record that their spouse also lived at the home. Another person was receiving end of life care and their care plan had not been updated to reflect this. One person was having their food and fluid monitored but the care plan did not record the reason why. Monitoring charts were used to record people's food and fluid intake when this has been identified as an area of concern, and to record positional changes, but these had not always been completed accurately. We discussed this with the registered manager, who acknowledged that staff were not updating care plans as required. They assured us that this matter would be dealt with straight away.

Care plans recorded the level of support people needed to carry out day-to-day tasks, such as showering, moving around the home and eating their meals. In addition to this, they recorded people's likes and dislikes, their care preferences and their hobbies and interests. We asked staff how they got to know about people's individual needs and they told us they read care plans, they spoke with relatives and they closely observed people. Staff told us, "We read the pre-assessments completed by the manager, and we speak with people and their family" and "We discuss people at handover meetings and read care plans. As we find out more about people, we add more information to the care plan." We found that care plans included sufficient information about people to assist staff in providing care that was centred on them. In the dementia areas of the home, there was a record of 'blue dot' time. This was what the home called the one-to-one time staff spent with people.

Staff appeared to have a genuine understanding of the needs of the residents. One person told us, "They have had the same staff for a number of years and they know what I like and dislike." At lunchtime we saw that staff were aware of people's likes and dislikes, and which of them needed help or encouragement to eat. Staff knew not to use a placemat on the dining table for one person, as this confused them. We observed that staff knew when someone was becoming agitated or restless and how to distract them by providing a soft toy or a rummage bag. Rummage bags are bags containing tactile items that are used to occupy or distract people and help them to be less anxious.

Handover meetings were held to pass information from one shift to the next. In addition to this, the home held '11 at 11' meetings. One representative from each area of the home attended these meetings, where they discussed anyone who was ill and any individual concerns.

Both relatives / visitors who we spoke with confirmed they felt there was good communication between themselves and staff at the home and that they were kept informed of any events concerning their relative / friend. Some people had their own telephones and computers. This helped them to maintain their independence and to keep in touch with family and friends. People were able to have visitors at any time of the day or evening.

People told us they could choose to spend time in their own rooms or in communal areas of the home; most people chose to spend time in one of the lounges. People were encouraged to personalise their rooms to make them feel more familiar and homely. This included bringing in items of their own furniture and photographs.

Various activities were taking place in the dementia area of the home; these included making Easter cards, baking, reading newspapers and singing with people. Staff were spending one-to-one time with people, or interacting with people in small groups. This resulted in a calm but friendly atmosphere where it was clear people felt 'at home'.

In the residential area of the home, the two activities coordinators provided a full programme of activities that were recorded in a brochure and on a notice board. These evidenced that there were activities on offer every day. We observed an exercise session on the day of the inspection and observed that staff encouraged people to become involved. There had recently been Italian and Thai evenings; the Thai evening included traditional dance. Trips out were organised by the home, and people also organised their own visits out of the home, either alone or with relatives. Any activities that people had taken part in were recorded on progress notes within their care plan.

The main lounge had a stage where entertainers could perform and a projector so that films could be shown. There was a library, and each Tuesday the 'Friends of Connaught Court' organised a shop selling items such as toiletries and sweets. Two hairdressers visited the home on a regular basis. Some people made their own appointments as they would if they lived in the community and others needed support to make an appointment.

The complaints policy and procedure was displayed around the home and was included in the home's statement of purpose. The complaints log showed that any complaints received had been investigated and there was a record of the outcome. There was also a record of any compliments received; there had been two in February 2017 and 10 during 2016.

None of the people we spoke with had made a complaint about their care, but they told us they would speak to the registered manager or a member of staff if they had any concerns. Staff told us that people were listened to if they expressed concerns or made a complaint, and that they would support someone to make a complaint if needed.

A satisfaction survey had been distributed to people who lived at the home. The responses had been collated and the analysis recorded that 97% of people were satisfied with the overall standard of care and 87% were happy living at the home. The analysis was in written and graphical format and was displayed within the home.

There was an active resident's committee. Meetings were held each month and the minutes showed that people took an interest in the running of the home. For example, they had recently decided that they wished to keep the main meal at lunchtime. The minutes of the most recent meeting were displayed on the notice board, and there was a notice advertising the next meeting on 30 March 2017. There was also an active

'Friends of Connaught Court' group.

Good

Is the service well-led?

Our findings

There was a manager in post who registered with CQC in August 2016. 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 deputy manager and an assistant manager, who were employed in addition to staff recorded on the rota.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely. We found the registered manager had notified the Care Quality Commission and other agencies of incidents which affected the welfare of people who used the service.

Staff told us they were happy with how the home was managed. Comments included, "Management is fair. I feel comfortable talking to [Name of registered manager]", "Their door is always open and there's always someone to ask", "Managers listen and are very considerate" and "The manager empowers staff." People who lived at the home knew who the registered manager was, and told us they could approach them at any time.

The registered manager told us about the newly introduced continuing improvement programme (CIP). They said that any serious concerns identified in quality audits would be recorded on the CIP and would be investigated. It was reviewed monthly at the organisations head office, and responsibility was allocated for any actions that needed to be carried out.

The registered manager carried out a variety of quality audits to monitor that the systems at the home were working effectively and that people received appropriate care. These included audits of care plans, infection control and medicines. The most recent infection control audit had been carried out in February 2017. The care plan audit had identified missing documents or documents that needed to be updated. Although the forms had an area to record comments and concerns, we found it was not clear when any required actions had been completed. This would have provided a more complete picture of the issues identified and the action taken to address the shortfalls.

We asked staff to describe the culture of the home. They described it as person-centred and additional comments included, "Working here has changed my view of life. I love supporting people with dementia", "It's a pleasant home to work in – we have privileges such as free meals and drinks – we are lucky", "I would recommend the home to others" and "It's less like a care home and more like a home." One relative had written in the home's comments book, 'We were privileged that our mum was in your care. Everyone that we met showed special qualities and the staff who looked after her were simply wonderful'.

Various staff meetings were held, including meetings for residential staff, for senior staff and for night staff. One member of staff said, "We can always discuss any concerns. If I have a point to make, I am listened to."

The home had a relative's forum. These meetings were held three times a year, usually in the form of a cheese and wine evening. The registered manager provided an update on the service, including things that had gone right and gone wrong. At the meeting in February 2017 a speaker from the Alzheimer's society had been invited, and only five relatives had turned up. As a result, the registered manager had decided to reduce these meetings to one a year, and to use a newsletter instead to remain in contact with people's relatives and friends. Relatives were also issued with an annual survey. We saw the survey for 2016 included positive responses about staff, management, care provision, the environment and the home's social life.

Staff told us that there would be learning from any incidents that occurred at the home. One member of staff said, "We would look at what went wrong. We would ask what and why. We would re-look at risk assessments."

A home manager's competition called 'People to Shine' was advertised on the notice board. Staff were invited to take photographs of events, the environment and everyday moments to capture person-centred care, and what staff did well. Prizes were going to be awarded to the winning team. This showed that staff were encouraged to recognise good practice.