CityCare Connect Limited

Connect House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12, 15, 16 and 19 September 2016, it was an unannounced inspection. Connect House is run by CityCare Connect Limited. The service is registered to provide accommodation for 56 people who require nursing or personal care. Connect House is situated in Basford in Nottingham.

Connect House is a wholly owned subsidiary organisation of CityCare Partnership and staff work closely with staff employed in CityCare partnership. The service is split into two distinct units, Heritage Suite and Garden Suite. Heritage Suite has been open since 2014 and provides a reablement service to people who have recently been discharged from hospital to help them regain their independence. Heritage Suite is supported by a range of health professionals including physiotherapists, occupational therapists and nurses. During our inspection there were 19 people in Heritage Suite.

Garden Suite has been open since January 2016 and provides nursing care for older people. Together with the hospitals they are piloting a healthcare of older people project aimed at facilitating discharge of people with complex health needs from hospital. Garden Suite is staffed by nurses who are on rotation from CityCare Partnership and health care assistants and is supported a range of visiting clinicians including GP's, Consultants and specialist nurse practitioners. During our inspection there were 25 people in Garden Suite.

When we last inspected the service on 28 May 2015, we found a breach of the legal requirement related to person centred care. We asked the provider to make improvements in this area and during this inspection we found that the required improvements had been made. We also received additional information of concern following our previous inspection. We undertook this comprehensive inspection to check whether or not the service now met legal requirements, to address the information of concern we had received and to provide a rating for the service.

The service provided by Connect House was innovative and pioneering and people were enabled to access expert support from a range of specialist health professionals. However when people had specific health conditions staff did not have access to clear information in care plans to enable effective support and monitoring.

People's medicines were not managed or handled safely. Although people felt safe the service the risks associated with people's care and support had not been identified or managed appropriately. Assessments had not been carried out in line with people's individual needs and people's care records did not contain sufficient guidance for staff to minimise risk.

Equipment used to support people was not always used safely. People were not supported to maintain adequate levels of hydration and nutrition and where people required specialist diets these were not always provided.

There were enough staff to provide care and support to people and staff understood their responsibility to

protect people from the risk of abuse. However we found that people were supported by staff who had not received adequate training and we found that not all staff were provided with regular supervision and support.

People's rights under the Mental Capacity Act (2005) were not respected. Where people had capacity they were not always effectively involved in day to day decisions. However people, and their families, were involved in aspects of care planning and had a good understanding of the purpose of the service.

End of life care was not provided in a dignified manner and people who used the service were not always spoken about in a respectful way. People did not always receive personalised care that met their needs because records were not tailored around individual needs and preferences.

Systems in place to monitor and improve the quality of the service were not effective which resulted in negative outcomes for people using the service. Staff did not always have a good understanding of their responsibilities.

People were enabled and encouraged to be as independent as possible. People were supported to maintain relationships with family and friends and were provided with the opportunity to get involved in activities. People's right to privacy was respected.

The management team were open, approachable and responsive. Feedback was encouraged and people were supported to raise issues and concerns and there were systems in place to respond to concerns and complaints. People and staff were involved in giving their views on how the service was run.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, consent, nutrition and hydration and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's medicines were not managed or handled safely.

Risks to people had not been identified or managed appropriately. Assessments had not been carried out in line with people's individual needs. People's care records did not contain sufficient guidance for staff to minimise risks to people.

Equipment used to support people was not always used safely.

People felt safe in the service and staff understood their responsibility to protect people from the risk of abuse.

There were enough staff to provide care and support to people.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights under the Mental Capacity Act (2005) were not respected.

People were not supported to maintain adequate hydration and nutrition.

People were supported by staff who had not received adequate training. Not all staff were provided with regular supervision and support.

People had access to specialist health care professionals. However when people had specific health conditions staff did not have access to adequate information to enable effective support and monitoring.

Is the service caring?

Requires Improvement

The service was not consistently caring.

End of life care was not provided in a dignified manner.

People who used the service were not always spoken about in a respectful manner.

People were not always effectively involved in decisions about their support.

People were enabled and encouraged to be as independent as possible.

People had their right to privacy respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive personalised care that met their needs because records were not tailored around individual needs or preferences.

People were provided with the opportunity to get involved in activities.

People were supported to maintain relationships with family and friends.

People were supported to raise issues and concerns and there were systems in place to respond to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to monitor and improve the quality of the service were not effective. Staff did not always have a good understanding of their responsibilities.

The service provided by Connect House was innovative and pioneering. People were enabled to access expert support from a range of specialist health professionals.

The management team were open, approachable and responsive to feedback. People and staff were involved in giving their views on how the service was run.

Connect 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. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 28 May 2015 inspection had been made, to look at the overall quality of the service and to look at concerns we have received since our last inspection.

We inspected Connect House 12, 15, 16 and 19 September 2016. This was an unannounced comprehensive inspection. The inspection team consisted of two inspectors, a pharmacy inspector, a specialist nursing advisor and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During the visit we spoke with 15 people who used the service and the relatives of four people. We also spoke with 10 members of care staff, three nurses, the cook and kitchen assistant, two activities coordinators and the head of house-keeping. In addition to this we talked with the assistant director of clinical services, the director of nursing and allied health professionals, the registered manager, the deputy manager and the unit lead for Heritage Suite. We spoke with a range of visiting health professionals.

We observed care and support in communal areas in both Heritage and Garden Suite. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records of 11 people who used the service, medicine administration records for 16 people, staff training records and four staff files, as well as a range of records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were stored securely within the recommended temperature ranges for safe medicine storage. However, medicines stored in the medicine trolleys were not always well organised and we found more than one box of the same medicine in use and discontinued medicines still in the trolley. This increased the potential of a medicine error.

Medicines were not always dated when opened. This meant it was not possible to determine whether the medicine was being used within the manufacturers recommended shelf life. We also found medicines which had been dated when opened but were still in use beyond their 28 day expiry date. This meant that medicines were being used longer than the expiry date and may no longer be effective. Controlled drugs which required separate storage arrangements due to their potential for misuse were stored securely in dedicated controlled drug cupboards. However, we observed that the cabinet in Garden Suite was also used to store people's money and other personal items. It is important that only controlled drugs are stored in this cabinet to reduce unnecessary access to this area.

People could not always be assured that they would receive their medicines as prescribed. Medicines were not always available to give to people. We found one person was without pain relief on the day of the inspection. We found a further two people had not had some of their prescribed medicines on various dates because they were not available. The deputy manager explained that there were ongoing problems with people being discharged from hospital without a sufficient supply of medicines and they informed us that actions were underway to resolve this. We acknowledged that some of these problems were a system failure outside the services control but explained the importance of ordering medicines in a timely manner with a procedure in place to chase prescriptions was the responsibility of the service.

Records of medicines available were not always accurate. Medicines were not booked in correctly when they entered the service which made it difficult to check that people had been given their medicines. For example, we looked at a MAR chart for one person prescribed a medicine to prevent blood clots. Although the MAR chart documented that the person had been given the correct prescribed dose it was not possible to check that the person had been given their medicine as prescribed because there was no record of receipt and no total balance recorded.

We found gaps in three people's medicine administration records (MAR). This is when there is no staff signature to record the administration of a medicine or a reason documented to explain why the medicine had not been given. We also found that when people were prescribed a variable dose of a medicine such as 'Give one or two tablets' the actual amount was not always recorded on the MAR chart. It was therefore not possible to determine if the person had been given the maximum prescribed dose or if a second dose could be given if needed.

Handwritten MAR charts were not always completed correctly or checked by two staff. This is important to ensure that accurate information about people's medicines has been documented. We found one person's handwritten MAR chart did not match the directions on the pharmacy label attached to the medicine. There

was no signature on the MAR chart and it was not possible to identify who had written the chart. It was not possible to determine how many tablets had been given to the person or what the correct dose was. Another person had been prescribed medicines which were intended to be given if they became unwell. These are called 'anticipatory medicines'. However, these medicines had not been recorded onto the person's MAR chart. This meant that there was no record of them in the service.

When people were prescribed a pain relief skin patch, records did not show where the patch had been applied. We looked at one person's records and although we found a chart for recording the position of the patch staff had not completed the chart since the 6 August 2016. This would ensure staff could check that the old patch was removed before applying a new patch and to make sure the site of application is rotated to minimise side effects such as skin irritation.

We were shown copies of monthly medicine checks that the service undertook which identified areas for improvement; however they had not been effective in identifying all the issues found during our inspection. We spoke with the Deputy Manager who was aware of some of the issues identified and agreed that improvements were needed particularly on Garden Suite. During the inspection we saw that the management team had taken swift action to implement improvements to the way that medicines were stored and managed. The registered manager also shared a 'medicines management improvement strategy' which had been developed in response to our feedback.

Risks to people's health and safety were not properly assessed or well managed. People were put at risk of choking. Systems to ensure that people were served the correct food to reduce the risk of choking were not effective and some staff did not have a good knowledge of specific dietary needs. In Garden Suite we saw that one person had been assessed by the Speech and Language Therapy (SALT) team as being at risk of choking and required supervision whilst eating and a specific consistency diet to reduce this risk. We observed that the person was not served their food at the required consistency and was not supervised whilst eating. The person started to cough when eating which may have indicated that they were struggling with the consistency of the food. Staff did not attend to the person and they did not eat the rest of their meal.

In Heritage Suite a person who used the service had been assessed as requiring a soft diet to reduce the risk of choking. There was no clear information in the person's care plan about what types of food should be avoided and we saw records that the person had been served food types which are considered high risk for people at risk of choking. We spoke to a member of staff about this person's diet and found that they did not have a clear knowledge of what foods should be avoided. They told us, "I guess it depends on how hard they (food) are." There were not always risk assessments in place in relation to choking and where there were they did not contain adequate detail. For example one person had a choking risk assessment in place but it did not detail how staff should respond should the person show signs of choking.

We found that the approach to managing risks associated with pressure ulcers was inconsistent. In Garden Suite the risk of people developing a pressure ulcer was not assessed and planned for safely. Pressure ulcer risk assessments were completed and people who had been assessed as being at risk of developing pressure ulcers were provided with equipment to reduce the risk. However, staff did not always have a good knowledge of this and care plans did not provide adequate detail of equipment or how it should be used. One person had been assessed as requiring a specialist mattress to reduce the risk of skin damage. The care plan did not specify the required settings for the mattress. During our visit we found that the mattress was not set at an appropriate level for the person's weight. This meant the person's mattress would not have been effective in preventing pressure ulcers. We also saw that in Garden Suite that re-positioning charts for people at high risk of developing pressure ulcers were not being completed at the specified timescales. For

example records completed prior to our visit showed that a person who required assistance to change position every two hours did not have any recorded position changes for a period of over seven hours. This increased the risk of people developing skin damage.

It was not always clear where pressure ulcers had developed. Although some care plans clearly recorded that the person had been admitted with the pressure ulcer this was not recorded for all people. This made it hard to ascertain if the service could have done more to prevent skin damage.

In Heritage Suite we found that the risks associated with pressure ulcers were managed more effectively. Risk assessments were completed, care plans specified how frequently people should be supported to change position and records of positional changes were completed at the required timescales. However these people's care plans also lacked specific details about the equipment in place to reduce the risk of people developing a pressure ulcer such as settings for pressure relief mattresses. Following our visit the registered manager informed us that they planned to take action to streamline and improve recording related to pressure ulcers.

The approach to managing falls was inconsistent. In Heritage Suite falls risk assessments were not always in place as required. One person did not have a falls risk assessment, despite having sustained a recent fall and using a walking aid to mobilise, there was no clear information about any controls in place to reduce the risk. This put the person at risk of further falls. However in Garden Suite we found that individual risk assessments had been completed to assess people's risk of falls and actions to reduce the risks had been identified.

Equipment to support people with their mobility was not used safely. There was no formal process for assessing the size or type of sling to be used for the person and no records in care plans about this. A sling is attached to a hoist to assist people to transfer and is available in different sizes according to people's weight. Whilst some people had their own sling stored in their room other people used communal slings. Care staff told us they used their own judgment about the size required. In view of the number of temporary staff and staff who were unfamiliar with people's needs, safety risks were increased by not identifying the correct slings to be used. Following our visit the registered manager informed us that they would be working with a specialist health professional to assess for and allocate slings.

In Garden Suite some people communicated with behaviour which may challenge staff. We found this was not being assessed or planned for appropriately. Care plans did not detail triggers for this behaviour or specify how staff should respond to ensure the person's safety and to protect themselves. For example one person sometimes behaved in a way that may have caused injury to staff. The person's care plan did not contain adequate detail of how to support the person in the least restrictive way possible and there was no risk assessment in place. In addition to this records showed that when the person behaved in this way staff often left them alone in their room to calm down. The person was at high risk of falls and whilst we saw that staff had recorded that they had put equipment in place to reduce the person's risk of falls when leaving them alone this was not stated in the person's care plan. This lack of information put the person at risk of falling. The deputy manager told us they had already identified this as an area for improvement and they were planning to amend the behaviour plan. Following our inspection the management team informed us that they would be working with a specialist health professional to develop support plans for people.

All of the above information was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that they felt safe at Connect House. One person told us, "I feel safe because

they are doing their job", another person told us they felt safe because staff were "Taking care of my needs and I am getting physio." We spoke with a relative of someone who used the service who told us they felt the service was safe as "(People) are checked pretty rigorously." Another relative we spoke with told us that they felt the building was safe and secure, they said, "They (people who used the service) are pretty secure because people can't wander in and out."

There were systems and processes in place to minimise the risk of abuse and staff had received training in protecting people from abuse and avoidable harm. Care staff, including agency staff and nurses we spoke with had a good knowledge of how to recognise different forms of abuse and understood their role in reporting any concerns or allegations to the registered manager. One member of staff we spoke with told us they would report any concerns to the deputy manager or the lead nurse and told us that they had an 'on call system' which could be used to contact a manager out of hours. Staff were confident that any concerns they raised with the management team would be dealt with properly. We saw records which confirmed the management team had taken appropriate action in response to previous issues and had made referrals to the local safeguarding team as required.

We received very mixed feedback about staffing levels across both Heritage and Garden Suite. Some people using the service and their relatives told us that they felt that the service was short staffed and that this had an impact on the care people received. One person told us, "I pressed the bell twice but staff did not arrive in time." Another person said, "I don't mind waiting for staff to support me." A relative we spoke with told us, "[Relation] needs help all the time but have to wait a lot because they (service) are saving money" another relative told us, "I think they are short staffed". Other people we spoke with felt that staffing levels were adequate, one person told us, "I don't have to wait to long for help, I have no grumbles."

Staff also had mixed views on staffing levels at Connect House across both suites. One member of staff we spoke with said, "I like working here, there are more staff on than other places I have worked". However other staff members told us that staffing levels varied. One member of staff explained that they did not feel that there were enough care staff on duty at times when the dependency of the people using the service was high. Another member of staff told us that there were specific times of day that were more challenging than others such as meal times and mornings and evenings and they felt that people were left waiting for longer than they should be at these times.

Although we received mixed feedback regarding staffing levels, during our inspection we found that staffing levels were sufficient. We reviewed rotas which showed that the service was staffed to the level determined by the provider. The registered manager told us that they had flexibility in their staffing levels and could increase this based upon the number of people using the service and the complexity of their support needs. The management team were honest and open about the current challenges in recruiting staff, in particular nurses. Temporary agency staff were used on a daily basis and the registered manager explained that they endeavoured to use the same agency staff to ensure continuity of care. Some people who used the service expressed that they were not happy about the use of agency staff, one person said, "They got a lot of agency staff in and I really don't like that." However staff we spoke with said the use of agency nurses did not have a major impact because regular agency staff were used. One member of staff told us, "We couldn't cope without them (agency staff)."

People could be assured that safe recruitment practices were followed. The service had taken the necessary steps to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of ID and references had been obtained prior to employment and were retained in staff files.

People were protected from risks associated with the environment. We saw there were systems in place to assess and ensure the safety of the service in areas such as fire and legionella and measures were in place to reduce these risks. Staff had been trained in health and safety and how to respond if there was a fire in the service. There were personal evacuation plans in place detailing how each person would need to be supported in the event of an emergency such as a fire. The registered manager had identified that improvements were needed to evacuation procedures for people unable to use a wheelchair and they were in the process of exploring options.

Requires Improvement

Is the service effective?

Our findings

People were not always provided with adequate nutrition and hydration. In Garden Suite we found that people were not always provided with enough to drink. We spoke with the relative of someone who used the service and they told us, "I do worry about [name] becoming dehydrated." Although fluid charts were kept for people these were not effective as they had not been fully completed and there was not always evidence that the records were analysed to identify issues and concerns. Some fluid charts showed that people identified as being at risk of dehydration sometimes went for long periods without being offered a drink. On the second day of our inspection we observed that one person was not offered a drink with their meal, we later checked the person's records which recorded that the person had been provided with a drink at lunch, this was not the case. This put the person at risk of dehydration. The management team took swift action on this and we observed improvements in the provision of drinks and recording for the remainder of our visit.

We found that in both Garden and Heritage Suite people were not protected from the risks associated with eating and drinking. Where people were at risk of choking, risk assessments were not always in place and people were not provided with the recommended specialist diets or supervision required to reduce this risk. For example one person in Garden Suite was not served food of the required consistency and although we fed this back to the management team we found that on the fourth day of our inspection the kitchen still did not have accurate information about the person's dietary requirements. We informed the deputy manager who ensured that the person was served food of the correct consistency.

In Garden Suite risks associated with people losing weight were not managed effectively. One person lost just under four kilograms in three months, this had not been identified and there was no evidence of any action having been taken to monitor this or prevent further weight loss. We also saw that records were not always completed accurately. For example we observed a meal time and noted that one person ate very little of their meal. We checked the food record for this person later in the day and found that it had been recorded that they ate their full meal. This was not accurate and put people at risk of malnutrition.

People using the service told us that the food quality was variable. One person who used the service said, "Food could be better," another person told us food is, "Sometimes poor quality, no fruit." We spoke with a member of staff about the food served during our visit and they told us, "It was terrible, no one liked it and there was nothing else on offer. It's normally okay." We spoke with the kitchen team who had a good knowledge of the preparation of specialist diets, however they had not been provided with accurate information about people's needs. The registered manager explained that they had been through a challenging period with their kitchen team and were currently using a high level of agency staff, they assured us that they were aware of the issues and were working to address this.

People's cultural needs related to food were not identified or met. The service supported people from a diverse range of cultural backgrounds and staff told us that they felt that people were not provided with food choices appropriate to this. One member of staff told us that there was a, "Lack of multicultural food, people need to ask more what they (people who used service) would like. Maybe because they (staff) are agency staff." Another member of staff told us that they felt that people should be offered food to match

their cultural preferences, they informed us that there were two people using the service who had requested a specific diet but that, "They are just given what the others have." We discussed this with the registered manager who informed us that they had only just been made aware of this feedback and they would take action on it.

Meal times were not well spaced. The service operated a protected meal times policy where meals were served at specified timeframes and although we were informed by the management team that this was flexible we did not see this in practice. For example we observed that one person finished their breakfast at approximately 11.45, they were then served their lunch at 13.30 and dinner at 16.45. They were not offered an opportunity to defer their lunch after they had chosen to have a late breakfast. This did not facilitate effective nutritional intake.

We shared our feedback with the management team who informed us following our visit that they had developed an action plan to address the issues we found. This included improvements to food and fluid recording, development of systems to make modified diets clearer and training for staff however this had not yet been implemented.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People in Heritage Suite were provided with frequent drinks throughout the day and recording was completed accurately. Staff were aware of people's care and support needs related to hydration and we saw that support was effective in this area.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not protected as the principles of the act were not correctly applied. MCA assessments and best interest decisions were not in place as required. In Garden Suite we found that decisions were made on people's behalf without first assessing if the person had the capacity to make a decision for themselves. For example one person had a motion sensor in their bedroom which they were unable to consent to, however no capacity assessment was in place. Another person was not able to consent to the content of their care plan and other aspects of their care and treatment, but there were no MCA assessments relating to this. A consent form had been signed by the person's relative 'on behalf' of the person but there was no indication that this relative had any legal powers, such as a Health and Welfare Power of Attorney, to provide consent on behalf of the person.

In Heritage Suite we saw one person's care plan which stated the person's capacity was 'variable', but there was no MCA assessment in place and the care plan did not contain any further detail about how to support the person with decision making to maximise their capacity.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager and deputy manager had a limited understanding of DoLS. There were people who used the service whose care and support may be considered a deprivation of their liberty however the appropriate authorisations were not in place. For

example a number of people lacked the capacity to consent to their care, had their freedom restricted by locked doors and were either under the continuous supervision of staff or had equipment in place that continuously monitored their movements.

Staff had a basic knowledge of the MCA but were not able to clearly describe how the act applied in their role. We saw that some staff had not had any training in the MCA or DoLS.

Following our visit the registered manager informed us that they had taken action to complete MCA assessments and DoLS applications where required. They also had further plans to develop staff knowledge and competency however this had not yet been implemented.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had capacity to make decisions about their care and support staff spoke with people and gained their consent before providing assistance and staff respected people's decisions. For example, people were offered a choice of meal and where a person decided they did not want the food served an alternative option was offered. Consent forms were in people's care plans. These had been signed by the person or there was a record the person had provided verbal consent if they were unable to sign. However when movement sensors were in place there was no evidence of consent being sought for this.

Staff we spoke with gave variable feedback about the training they had received at Connect House. One member of staff told us, "(We) need lots of training." Another member of staff said "It (training) is not really sufficient but I know they (managers) are working on it." Staff we spoke with identified gaps in end of life training, MCA and DoLS and mouth care. Feedback about the medicines training people received was also mixed. Whilst some nurses we spoke with felt that they had been provided with effective medicines training, one nurse we spoke with told us they had not received adequate medicines training when starting at the service. Despite this people told us they felt that staff were trained and competent. One person's relative told us, "The staff know what they are doing."

Records showed that staff had received training in a range of areas. This included moving and handling people, safeguarding and health and safety. In addition to this some staff had completed training related to people's individual needs such as dementia care. Staff we spoke with told us they felt able to request additional training if needed and had recently identified they would like more training in working with people who have behaviours which may challenge staff. The registered manager told us that they had identified a number of areas where they felt that staff required additional training such as manual handling, equality and diversity, MCA and DoLS and modified diets and they gave assurances that they had put plans in place for this training.

The registered manager told us that new staff were provided with an induction period covering all of the provider's mandatory training. Four recently recruited members of staff we spoke with were positive about their induction and told us that they had been on a thorough training course and then had completed a number of shifts shadowing more experienced staff. One member of staff told us "The four day induction is brilliant."

The registered manager told us that new staff were in the process of completing the care certificate. The care certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care.

Agency staff we spoke with told us that they received training from the agency and had been given an orientation to the building which included the fire procedure on the first occasion they worked at Connect House. The registered manager told us that if they identified that agency staff had any training needs they would raise this with the agency, they also shared with us that on occasion agency staff were invited to attend training courses at Connect House. Agency staff told us that there was a comprehensive handover system at Connect House which enabled them to gain an overview of each person's care needs and we observed this to be the case.

The registered manager informed us that staff received a mixture of group and individual supervision. However a number of care staff we spoke with could not recall having a recent supervision, one member of staff told us, "I can't remember the last one (supervision) I had, yes it would be useful to have a chance to voice my opinion." Records showed that whilst nurses and senior staff had received regular supervision some care staff had not received supervision for over six months. Those staff who had received supervision were positive about it. One member of staff told us, "Supervisions are very helpful, you can open up and tell them how you feel."

People could not always be assured that they would receive effective support with health conditions. People's care plans did not consistently provide an adequate level of information to enable staff to provide effective support nor did they contain guidance for staff on how to recognise that a person's health condition may be worsening. For example one person's assessment documentation recorded that they had a particular health condition, however this was not recorded anywhere in their care plan which meant there was no clear information for staff about the condition and how it affected the person. Another person had a health condition which meant that their vital signs needed to be monitored regularly. Although records showed that this monitoring took place at the required intervals there was no guidance for staff about the person's normal levels, or the levels at which action should be taken. We spoke with a nurse who told us that any levels below normal would be reported to medical staff or if out of hours they would ring 111. We saw that this person's vital signs had fallen below normal levels but could not find evidence of any action taken to respond to this or to repeat the observation. This meant staff may not realise if the person's health condition was deteriorating and there was a risk that people may not be enabled to access support from external health professionals if needed.

In Heritage Suite people were provided with access to health and therapy services to aid their rehabilitation. Heritage Suite was supported by a range of health professionals including physiotherapists, occupational therapists and nurses. Guidance from professionals was incorporated into people's care plans which included clear instruction for care staff about how to support people in their rehabilitation. Care staff we spoke with were clear about their role in acting upon the advice of healthcare professionals. A GP also visited the service frequently to ensure people had access to primary medical services. They spoke very positively about the impact the service had on the lives of the people who used it saying, "We have come a long way, the transformation in terms of quality of outcomes (for people using the service) has been superb."

In Garden Suite people were supported in their recovery by a team of specialist health professionals. As well as CityCare staff, Nottingham University Hospitals Trust provided a team to support the service. A community geriatrician and registrar visited weekly. Advanced nurse practitioners and junior doctors also supported the unit. We talked with the community geriatrician who told us the scheme had been initially introduced as a pilot and had been extended as it was felt to be meeting a need. They told us they had been, "Amazed" that people who had been at high risk of re-admission to hospital, had spent time at the service and had been able to be discharged back to their own home or had gone to residential care.

Requires Improvement

Is the service caring?

Our findings

End of life care was not provided in a dignified manner. One person using the service was coming towards the end of their life and was fully reliant upon staff. We found this person to be in an unkempt state with the remains of a meal from the previous lunch time still in their mouth. Daily care records had not been consistently completed for this person and it was unclear when they had last received support with personal hygiene. The person was no longer able to communicate their preferences and they did not have a sufficient end of life care plan in place so the service held no information about the person's preferences.

The quality of end of life care planning was poor. We observed two care plans for people who were nearing the end of their lives. Both care plans were lacking important information about people's treatment choices at the end of their life and neither contained any information about their preferences for their last days of life. A member of staff we spoke with told us, "I know their wishes aren't in the care plans, so I ask them."

We spoke with one person's relative whose relation was very unwell. They felt that information had not been compassionately and clearly explained to them. Terminology had not been clearly explained to them and they were left feeling upset and confused. A member of staff we spoke with had a good knowledge of end of life care however expressed concerns about the competence of other staff in this area. They told us, "I think they should enforce end of life training, some staff don't understand it, it's a very sensitive area."

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We shared the above feedback with the management team who informed us that since opening Garden Suite in January 2016 they have supported 31 people who were coming towards the end of their life and had received positive verbal and written feedback on the care received.
People we spoke with gave mixed feedback about the approach of the staff team. Some people and family members told us that the staff were kind and caring saying, "When they (staff) come round in the morning with a cup of tea they always ask how I am and they seem interested." A relative of someone using the service told us, "They (staff) are always very friendly." A regular visitor to the service said they felt staff were, "Kind and caring," and they were positive about the care provided. However, other people we spoke with told us that the quality of support they received was variable. One person who used the service told us "Some staff are trained but not all, some just couldn't care less," another person said, "Staff are not always gentle when they are in a rush."

We observed that at times people were not spoken about in a respectful, dignified manner. In Garden Suite we heard staff members refer to people as their room numbers instead of their names. We heard two members of staff talking about people who used the service saying, "Put this one just here," and "Wheel them over." Another member of staff explained to us how they supported someone who sometimes chose not to have support with personal care however the language used did not promote the person's dignity.

We also saw many examples of positive interactions between staff and people who used the service in both Heritage and Garden Suite. Staff were kind, patient and spent time chatting with people throughout the day,

they were encouraging and worked at people's own pace. We saw one person being supported to move using a hoist and observed that staff were gentle and reassuring. The person appeared calm and relaxed throughout and it was clear they had confidence in the staff. Staff used gentle touch and affection to reassure and support people. One person who used the service had a particularly unsettled night and we saw a staff member gently soothed the person until they fell asleep. Staff responded quickly when people were showing signs of distress. One person became upset at a mealtime, a member of staff acted quickly to provide affectionate support, rocking and singing with the person. The person quickly calmed and was assisted to eat their meal.

Staff were aware of people's likes and dislikes and used natural opportunities to talk to people about their interests in conversation. People's care plans contained a one page description of each person detailing their history, important relationships and individual preferences. We observed a staff handover during which staff demonstrated their knowledge of people and talked about people in a respectful empathetic manner.

People's spiritual needs were understood by staff. The registered manager told us that a multi-faith chaplain visited Connect House on a weekly basis. Staff demonstrated an awareness of people's individual beliefs and we observed staff engaging in conversation with people about this. One relative we spoke with praised the service for their knowledge of the person's religious beliefs, they told us, "They (staff) always get [name] ready for mass on a Sunday."

People were not always effectively involved in decisions about their support. Although most people we spoke with told us that they felt able to direct their own care other people told us that they felt that they were not listened to. One person told us, "I enjoy being here because they (staff) listen to me and do what I ask them." A relative of someone who used the service told us, "It's fair to say that when they make decisions they always keep [name] involved." However, one person told us "Staff aren't used to listening," and another person said, "Staff do interrupt conversations."

Whilst we observed that staff routinely checked with people about their preferences for care and support we found that choices were not always presented to people in an accessible manner. In Garden Suite we saw that information was not always provided to a people in a way that promoted informed decision making and choice. We observed a meal time and saw that people were not effectively informed about the choices available to them. Although there was a vegetarian option available people were not informed that one of the dishes was made using vegetarian mince. One person was offered "liver or mince" by a member of staff, they chose mince and they were not informed that it was vegetarian mince. Another person who was offered the same choice stated that they would just have potatoes and vegetables as they did not eat any animal products, the vegetarian option was not explained to them. This did not promote informed decision making and choice.

In contrast we found that in Heritage Suite staff had a good understanding of how to communicate with people in a way that was accessible to them. We saw that staff tailored their communication style to each individual and people were supported to make informed choices.

People were enabled to access advocacy services. Advocates are trained professionals who support, enable and empower people to speak up. On the second day of our visit an advocate from an independent voluntary organisation was visiting the home to support the relatives of someone who used the service. They explained that they visited Connect House weekly to support people who used the service and people's relatives. The registered manager also informed us that they would support people to access the services of an advocate as required and there was information about advocacy services displayed in the service.

People's right to privacy was respected. People using the service told us that staff respected their private space, one person told us, "Oh yes they always knock on (the door)." We observed staff knocking before entering people's rooms and ensuring that their doors were closed whilst providing personal care. A member of staff we spoke with explained how they respected people's privacy, "We make sure windows are closed, cover people with towels and make sure they are not supported by male staff if they don't want that." Some people chose to spend time in their bedrooms with visitors and staff respected their private space. We spoke with a relative of someone who used the service who told us that staff always checked what time they were staying until so that they didn't interrupt their time together.

People were supported to be as independent as possible and people and their relatives were clear about the purpose of the service. One person told us, "When I get physio they are quite clear in what they are trying to achieve." A relative of a person who used the service said "They are trying to re-establish independence."

In Heritage Suite there was a strong emphasis on building and maintaining people's independence and this was clearly reflected in the support provided and in care plans. Care staff worked with a specialist 'reablement' team who were located at Connect House and other external health professionals to enable people leaving hospital to build the skills and confidence to return to home. There was a training kitchen in the service and rehabilitation aids and equipment which were used by visiting health professionals. There was detailed information in people's care plans about the people's individual reablement goals. Staff had a good knowledge of people's skills and abilities and we saw that they encouraged people's independence where appropriate. A member of staff we talked with spoke proudly about their role in enabling people to regain their independence. They described a person who had had been fully reliant upon staff when they came to Connect House. The member of staff explained how they had worked together with the reablement team to build the person's skills and confidence and this had resulted in them regaining their independence and returning home. Another member of staff we spoke with told us, "It's good here because we help people improve, that hasn't happened in other places I have worked."

In Garden suite people with complex health and care needs were supported by a team of specialist health professionals to receive an assessment for their onward care. The management team explained that without the services provided by Connect House many of these people would not be safe to return to their homes. The registered manager shared the story of someone who had recently been successfully supported to achieve improved physical and mental health by the team at Connect House. The person had spent a significant time in hospital and came to Connect House in a confused and agitated state which resulted in them putting themselves at risk. Connect House provided a stable environment away from the hospital and enabled rapid access to specialist treatment and support. With the support of the extended team the person's condition stabilised and they were able to move into long term care. A close friend of the person provided feedback to Connect House, saying, 'I have been very pleased with the support [name] has been given and the improvement that has been made over the weeks. My heartfelt thanks to everyone.'

Requires Improvement

Is the service responsive?

Our findings

People could not be assured that they would receive care that was based upon their individual needs and preferences. In Garden Suite care plans were not personalised; pre-printed, standardised forms were used which contained generalised statements and did not provide any clear guidance for staff on some aspects of people's care needs. Personalised information had been added to some care plans, but others which had gaps to add specific information had not been fully completed. Whilst some parts of care plans were adequate other areas lacked detail and some information was missing or contradictory. For example one person's care plan stated 'ensure call bell left within reach' however in another part of the care plan it stated that the person was 'unable to use the call bell.' We shared this feedback with the management team who told us this was a particular challenge at Connect House due to the fast paced, short term nature of the service provided.

Where people had a long term health condition, some care plans were detailed however others were general and not focused on individual need. Some care plans had important information missing, such as the type of dressing to be used for a wound and the frequency of care to be provided. This meant that staff did not have access to personalised information about the support people required with health conditions or how people's health needs impacted on them. Staff we spoke with were not always aware of what health conditions people had or how to respond should people's health conditions worsen.

Some people using the service communicated with their behaviour. Care plans did not contain sufficient detail about how to support people in this area. For example, we saw that one person had charts in place to record incidents related to their behaviour. However there was no information in their care plan related to behaviours that challenged others. This lack of information meant that there was a risk that the person may not receive the support they needed or that support would not be provided in the least restrictive way possible.

The poor quality care plans observed in Garden Suite put people at risk of receiving unsafe and inconsistent support. The amount of temporary, agency staff in use at Connect House increased this risk. In addition to this both permanent and agency staff told us that they did not rely on care plans to inform people's care and support and instead relied upon other staff and information shared in shift handovers.

People were not always provided with support that was tailored to their preferences. A number of people we spoke with talked of "fitting in" with service imposed routines and staffing levels. One person told us "I get undressed (for bed) at six thirty because staff have other people to care for too," another person said, "Don't mind waiting first and last thing as staff are always busy then." There was limited information in people's care plans about their preferences for care and support and their preferred routines. Some care plans contained information about the person's preferences, where as other care plans did not have this information. This meant that staff did not always have access to information about what was important to people to inform their support.

Care records did not always provide an accurate record of support provided. In Garden Suite we found gaps

in recording which made it hard to ascertain whether or not support had been provided as required. For example one person's personal care chart indicated that despite needing full assistance with all aspects of their care, the person had not received any assistance with personal hygiene for five days in the month previous to our visit. We discussed this with the management team during our inspection who informed us that care was being carried out but accepted improvements were required with documentation. Another person had an exercise plan in place to aid their rehabilitation; care staff were responsible for supporting the person to complete these exercises. However the record of exercises had not been completed at all suggesting that the exercises had not been done. This put people at risk of not receiving the support they required to keep them healthy and safe. We shared this feedback with the registered manager who informed us that they had taken action to streamline recording paperwork thus making it clearer and easier for staff to complete. Spot checks were implemented during our inspection to ensure completion of care records and these spot checks were ongoing.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In contrast care plans in Heritage Suite were personalised. Each person had a succinct care plan which gave staff a clear oversight of their individual needs and preferences, they were up to date and had been reviewed regularly. People's care plans contained information about the person's level of independence and detailed where support from staff was required. Records also contained plans for supporting people to work towards their individual rehabilitation goals. Recording was completed at the specified intervals and we saw that these were completed accurately.

During our May 2015 inspection we found that people were not fully involved in the planning of their care and were not encouraged to follow their interests and activities on a regular basis. We asked the provider to make improvements in this area and during this inspection we found that the required improvements had been made.

People and their relatives were involved in some aspects of their care planning. The registered manager explained that due to the complex, short term nature of the service, involving people in care planning was challenging. Although very few of the people we spoke with could remember being involved in their care plan, records showed that people and their families, where appropriate, had been involved in an assessment when moving into the service and had been consulted about their preference and interests.

People were supported to maintain relationships with friends and family. People's friends and relations were welcomed into Connect House and we saw relatives spending time with their family members throughout our visit. One relative we spoke with told us, "(There are) no restrictions on visiting times for friends." Another relative said, "They look after us visitors when we come, always cakes and tea every time I am here." Relationships had developed between people using the service and we saw warm, friendly conversations between people. One person talked about how they valued the company of the other people using the service saying, "I've made friends with other residents."

People were enabled to take part in social activities, however feedback about activities at Connect House was varied. The majority of people we spoke with were satisfied with the activities available. One person said, "(There are) plenty of activities to pick from." Another person told us, "(I) enjoy afternoons with bingo." A relative we spoke with told us, "There are activities based on interests." However a small number of people we spoke with felt that they did not have enough to do with their time. One person told us, "It's boring, I can always find something to do at home (but) I sit here hour after hour and time drags," they went on to tell us "(I) need something to occupy my mind, fed up, there is nothing appropriate here."

The provider employed two activities coordinators who took responsibility for implementing a programme of activities across both Garden and Heritage Suite including quizzes, film screenings and reminiscence. Both activities coordinators were enthusiastic and committed to their role, one told us, "I enjoy seeing people involved, it makes my job worthwhile." Throughout our visits to Connect House we saw people meaningfully engaged in group activities. We observed a group of people playing bingo together, people were offered a choice about whether or not they wanted to join the group and staff supported and encouraged people's involvement in this. The service also had a hairdressing salon which was open at different points throughout the week.

We observed that whilst some people took part in activities others chose not to. The activities coordinators were mindful to spend time with these people on a one to one basis, encouraging reminiscence and engaging people in conversation. We also observed that care staff also spent time with people on a one to one basis and encouraged them to take part in activities which were meaningful to them. We saw a member of staff supporting one person who had been visibly anxious throughout periods of our visit to fold blankets; the person was calm and relaxed and looked to be enjoying the interaction.

People could be assured complaints would be taken seriously and acted on. People told us that they felt able to make a complaint and knew how to do so. A relative of someone who used the service told us, "I would know how to complain but would prefer for things to be sorted out before it got to that stage, I feel very lucky that [relation] is at this home. I visit every day and talk to staff on a daily basis." People and their relatives told us they felt comfortable raising a concern or complaint and felt confident that it would be acted upon.

Staff we spoke with knew how to respond to complaints if they arose, were aware of their responsibility to report concerns to a manager and were confident that the management team would act upon complaints appropriately. One member of staff told us, "If someone raised a concern or wanted to make a complaint I would listen and see if it was something I could resolve and would report it to the manager." There were posters throughout the service detailing ways in which people could provide feedback or raise a concern or complaint.

There was a robust system in place for handling and responding to complaints and we saw people's concerns were responded to appropriately in a in a timely manner. The deputy manager explained that complaints were discussed at monthly governance meetings and we saw records of this. The registered manager explained that themes from complaints were used to inform developments and improvements in the service. The service had recently received a number of complaints and concerns about laundry services, as a result of this the management team had made a number of changes to the laundry service offered and other improvements were underway.

People were also encouraged to give feedback about the service in a number of other ways. There were suggestion cards and boxes in communal areas and the service also promoted websites where people could leave their feedback on the service for members of the public to view.

Requires Improvement

Is the service well-led?

Our findings

Auditing and quality assurance systems were not always effective. Although the management team regularly conducted a wide range of audits they were not comprehensive which meant some important issues had not been picked up.

Garden Suite had been operating since January 2016 however the management team had not implemented care plan audits which meant that concerns we found in relation to the content of care plans, end of life planning, risk management and care records had not been not been identified or acted upon. In addition to this medicines audits conducted had not been effective in identifying and addressing issues.

A representative of the CityCare Partnership conducted a quality audit at Connect House twice a year. The most recent audit was conducted in May 2016. The audit rated Connect House as 'amber' which was defined as a '12 week timeframe for action'. However we saw that action plans developed by the management team in response to the findings of the audit were not fully completed and did not comply with the 12 week timescale specified in the audit. Consequently we found during our inspection that some of the issues cited in the report were unresolved. For example the last audit conducted had identified that, 'End of life advance care plans must be in place for those service users who are terminally ill, which will include any advance decisions made.' These were still not in place during our inspection.

This showed that the systems in place were not effective in facilitating improvement. Had effective systems been in place issues which placed people at risk of harm and impacted on their rights could have been identified and acted upon.

At times we observed that in Garden Suite there was a lack of oversight from the management team which led to disorganisation and impacted on the care received by people using the service. The provider did not have effective systems in place to observe or monitor the quality of the care provided on a day to day basis. The registered manager explained that they previously conducted spot checks of care provision but as the service had become more established these had stopped. During our visit we found that this lack of oversight resulted in negative outcomes for people using the service. Management levels were increased in Garden Suite throughout our inspection and we observed that this had a positive impact on the coordination and delivery of care.

Staff did not always have a good understanding of their responsibilities. The range of different support roles at the service, whilst being positive, contributed to a lack of clarity of responsibilities and some staff we spoke with felt that their role had not been fully explained to them. We spoke with two nurses whom had very different perceptions of their responsibilities; one nurse felt their role had been fully explained to them whilst the other nurse told us that their role had never been clearly defined. A member of staff we spoke with told us "It (Connect House) would benefit from more structure and coordination, they are gradually adding this, things like the unit lead role is good it has made it more organised."

We found that this lack of clarity had an impact on the care and support people received. For example one

person, who had sustained recent falls, did not have a falls risk assessment in place. We spoke with a member of staff about this who explained that these were normally completed by the reablement team and was not responsibility of care staff. This put the person at risk of further falls. We spoke with the registered manager about this who explained that Connect House staff had ultimate responsibility for ensuring the safety of people using the service. Our conversations with staff reflected they were not aware of this. We also found that no one held clear responsibility for ensuring that equipment to reduce the risk of pressure ulcers was at the correct setting. We shared this with the registered manager who took swift action to ensure that staff were aware of their responsibilities in this area.

Following our visit the registered manager informed us that they were planning to implement a care plan audit in Garden Suite and would also be implementing spot checks across the service, however these improvements had not yet been carried out.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In Heritage Suite quality assurance systems were more effective; the unit lead conducted a monthly care plan audit. We spoke with the unit lead who told us that upon completion of the audit they shared the results with team leaders who then made the required improvements to the care plans and we found this to be the case. Accidents and incidents across both Heritage and Garden Suite were analysed monthly to identify trends and to assess if any changes needed to be made. For example one person sustained repeated falls, this was identified and measures were put in place to decrease this risk. We saw that these measures had been effective in reducing the number of falls. Records showed that serious incidents were investigated using root cause analysis and action plans were developed to reduce the likelihood of repeat events.

There were systems and processes in place to monitor and improve the quality of other aspects the service. We saw that the management team conducted audits across the service such as health and safety, and infection control. There were also checks made on cleaning schedules and the kitchen and laundry areas. Where any issues were identified actions were recorded as being taken. The registered manager informed us that a clinical governance meeting was held monthly and attended by the management team and CityCare directors. The meetings focused on reviewing safety and quality and covered areas such as accidents and incidents and compliments and complaints. Records showed that where issues were identified action was taken. For example challenges experienced with the recruitment of nurses had been discussed and we saw that action had been taken to enhance the benefit package available to this staff group to try to attract more nurses.

The service provided by Connect House was innovative and was valued by people using the service, their families and professionals alike. The staff team worked closely with wider CityCare staff and other external health professionals to provide coordinated, specialist rehabilitation and nursing care. The registered manager explained that the "wrap around" service provided had resulted in positive outcomes for the people using the service; they told us "I've seen people come in here on a stretcher and leave walking." A nurse we spoke with told us, "(The) best thing about the service is the resources available and how fast things can be put in place due to the multiagency approach." Another nurse explained that they liked the fact they had access to a multi-disciplinary team and they could, "Bounce ideas off other people" and could ask for advice and support if they were unsure.

People told us they were generally happy at Connect House. One person told us, "(I) really like it here," another person said, "Happy with this place, love it." A third person told us, "Everything is good, I'm looked

after and it's clean." People's relatives were also satisfied with the overall service provided.

Both staff and managers were positive about the service provided at Connect House. The registered manager told us, "We look after people well, people want to stay here long term. We have an excellent staff team who support residents and relatives really well through difficult situations, in a positive way." Staff we spoke with enjoyed working at the service and talked about the strength of the team. One member of staff told us, "It's a good staff team, it's diverse and I feel accepted, it's not like other places." Another member of staff we spoke with told us, "I think everyone is cared for and it's generally a nice place to be." We also spoke with a number of health professionals who told us the service was "unique" and "invaluable."

People who used the service and their families were supported to have a say in how the service was run through managers surgeries, meetings and a satisfaction survey. The management team ran a weekly 'manager's surgery' on a Tuesday evening where people who used the service and their relatives were invited to discuss any issues and feedback with members of the Connect House management team. Due to the short term nature of the service regular meetings were not scheduled but were instead held as needed to share information, ideas and concerns. We saw a meeting taking place for people who used the service and their families during our visit.

A survey completed by people upon discharge form Connect House gave people an opportunity to provide feedback about their experience of the service. We saw records of the last satisfaction survey which was carried out in May 2016 and the scores were positive. People were 100 percent satisfied in some areas of support such as 'achieving rehabilitation potential' and 'feeling comfortable raising concerns' and scores in other key areas such as 'dignity and respect' and 'involvement in decision making' was also high. The results of the survey were on display in the service.

Staff were provided with opportunities to get involved in the development of the service. The registered manager told us they provided both formal and informal opportunities for staff to raise ideas and suggestions for improvements. Staff were provided with regular opportunities to meet with the management team and CityCare directors, staff meetings took place frequently and there were suggestions boards displayed in staff areas. Staff we spoke with felt able to make suggestions about the service but told us that they would welcome further opportunities for sharing their views. Two members of staff we spoke with told us that they had been unable to attend recent staff meetings due to the timing of the meetings. One member of staff said, "I've not been to any team meetings – it's not worked out with my shifts." We discussed this with the registered manager who told us they were aware of this and were exploring alternative ways of engaging with the staff team.

There was a registered manager in place who was passionate about her role. There was a clear management structure within the service including a deputy manager, unit lead and lead nurse employed to oversee the day to day running of the service. There was an on call system in place for times when management were not on site and one of the staff we spoke with said that when they had needed to call them about a concern the on call manager had been very supportive. The management team explained that they kept up to date with best practice in a number of ways, they told us "CityCare provide updates and alerts about changes in the sector and training on new developments. We have also attended Skills for Care manager's forums."

We checked our records which showed that the management team had notified us of events in the service. A notification is information about important events which the provider is required to send us by law.

Staff told us that they were happy working at Connect House and felt supported by the management team.

They were aware of their duty to whistleblow on poor practice and felt confident in raising any concerns with the registered manager. One member of staff said, "Management are very lovely and we can approach them any time. They come round and they know us by our names, we can be open and honest." Another member of staff told us, "If there was a problem, I could raise it and it would be sorted out." The registered manager was accessible and approachable. We spoke with a visiting health professional who felt that the management team were responsive. They told us they had previously raised some concerns and the management team had taken swift action to address this.

Throughout our time at Connect House the management team were open, honest and receptive to feedback. The registered manager prided themselves on their approach and told us, "The thing we are best at is being honest and taking action." Following our visit the registered manager took swift action to develop an action plan based upon the feedback we shared.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act 2005 were not respected Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not adequately protected from risks associated with their care and support. Regulation 12 (1) (2) (a) (b) (e) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from improper and degrading treatment. Regulation 13 (1) (2) (3) (4) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not supported to maintain adequate hydration and nutrition. Regulation 14 (1) (2) (a) (i) (ii) (b) (4) (a) (c) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not adequately protected from risks associated with their care and support. Regulation 17 (1) (2) (a) (b) (c) (f)