Innovative Aged Care Limited

Chelsea Court Place

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was the first inspection of the service and the inspection was unannounced. Chelsea Court Place is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 15 people living with dementia in one adapted building.

The home is purpose-built and designed for people living with different stages of dementia. The home provides 24-hour nursing care and is situated in the centre of Chelsea, with access to close transportation links and local amenities. People who use the service pay privately for their care and the provider offers bespoke services. At the time of the inspection there were 15 people using the service.

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

The building was designed to look like a hotel to reflect the experiences of people who had travelled and lived in hotels, as part of their previous occupation and/or social interests. People were referred to as 'members' and their rooms were referred to as 'suites'. People were provided with guest services and a unique mealtime experience. They were served beautifully presented meals by a head waiter and food cooked by an award winning chef. There was enough food and drink and people could eat the meals they wanted at the time they chose.

People had individual risk assessments detailing the risks to their health and safety, based on an assessment of their needs. Staff were familiar with risks relating to people's wellbeing and the systems in place to keep people safe from abuse.

Background checks were completed to ensure that staff were suitable to work with people; however some references were not authenticated. Each person was supported by two members of staff regardless of their care needs and there was enough staff deployed to help people when they asked for support.

Good systems were in place to ensure the safe administration, storage and disposal of medicines. Staff followed infection control protocols and people had access to personalised laundry and housekeeping services.

Staff had completed an induction, training and supervision to further develop their skills and knowledge. Care plans evidenced people's diverse needs and records were stored electronically and updated at the time people received care. Relevant external health practitioners had access to these. People were supported to live healthier lives and received regular visits from health professionals. Advanced care wishes

were written in people's care plans on how people wished to be supported at the end of their life.

Staff sought people's consent before carrying out care and support and they understood and worked within the principles of the Mental Capacity Act 2005 (MCA). People were looked after by staff who were kind and caring and their relatives and visitors were made to feel welcome when they spent time with their family members in the home. Staff respected people's dignity and privacy and were committed to ensuring people felt valued by giving them the choice to make day to day decisions about their care.

People took part in activities and events that were stimulating and personalised to their needs to help them continue to lead fulfilled lives. They were asked their views and suggestions to help shape the services and knew how to raise a complaint, and were confident any concerns they raised would be resolved.

People, their relatives and health professionals spoke favourably about the management of the home. There was a range of quality assurance systems in place to monitor and improve service provision. The provider worked in partnership with other services to ensure members of the public could access their facilities and sought new ways to develop changes to meet the needs of the people they supported.

We have made one recommendation about information being accessible to people in an easy read format.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew the correct action to take to keep people safe from abuse. Risks assessments had been updated to reflect changes in people's needs.

Recruitment checks were in place to ensure that staff were suitable to work with people using the service, but some references required verifying.

People had enough staff to support them when they needed help.

Medicines were managed safely and people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

The building was designed specifically for people who had travelled extensively and the environment was personalised to reflect their lifestyle.

People's nutritional needs were met and mealtimes were made to feel like a special occasion.

Staff were knowledgeable about people's care and trained to meet people's needs effectively.

Health professionals were available to give people treatment and advice and staff followed their guidance to ensure people led healthier lives.

People's consent was sought regarding their care needs in accordance with the Mental Capacity Act (MCA) 2005.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring and friendly when helping them in the home.

Staff placed an importance on maintaining people's independence and people chose how they would like to be supported.

Staff were respectful of people's privacy and their dignity was upheld.

People were provided with information about the service but this was not provided in an accessible format.

Is the service responsive?

Good

The service was responsive.

Staff demonstrated a commitment to providing high quality person centred care.

People were provided with a thorough assessment of their needs and their care plans were followed by staff to ensure they were responsive to their needs.

Advanced care wishes were written in people's care plans on how they wanted to be supported at the end of their life.

Complaints were recorded and monitored to improve the way the service delivered care.

Is the service well-led?

Good

The service was well-led.

People spoke positively about the management of the home and were kept informed about any changes to their care provision.

Staff were recognised and valued for the contributions they had made to people's care.

Systems were used by the registered manager to monitor the governance of the service.

The provider demonstrated best practice by working in partnership with other organisations.

Chelsea Court Place

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out an unannounced inspection of the service on 13 November 2017. The inspection team consisted of two 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including any notifications sent to CQC by the provider. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

During the visit we spoke with two people, two relatives and two people's visitors. We also spoke with the head of guest services, the activities coordinator, three care workers, the chef, a nurse, the deputy manager and the registered manager. We reviewed the records of six people's care files, including their medicines records. We toured the building and observed the care and support people received in communal areas. In addition to this we checked seven staff recruitment and training records, quality assurance audits and some of the records relating to the management of the service.

After the inspection we spoke with a consultant psychiatrist, the GP, physiotherapist and podiatrist to obtain further information about the service and the support people received.

Good

Is the service safe?

Our findings

People told us they felt safe. One person commented, "I feel very safe. Everyone is so happy, good, kind and helpful." A relative told us, "[My family member] has put on weight since being here. The process here is all interactive; I have nothing but amazement for it. It's the Ritz of the care world."

Staff explained they had completed training in safeguarding and had an understanding of who they would report to if they had concerns about a person's safety and welfare. Systems and processes were in place to protect people and make certain they remained safe in their home. The registered manager gave us examples of the processes they followed and understood their responsibilities about keeping people safe from abuse. The Care Quality Commission (CQC) had received one safeguarding notification about a person's behaviour that challenged the service. The registered manager explained they were liaising with the person's appointed social worker with a view to moving the person to another service. Multi-disciplinary meetings were in the process of being held every quarter to discuss and review people's complex needs to identity if there were any new ways of working with them and how to mitigate any risks. A whistleblowing procedure was accessible for staff to raise any workplace concerns and gave clear information regarding who concerns should be reported to, such as the CQC and other public organisations.

Risks to people health were assessed and managed to ensure people received safe care. There was a procedure to identify and manage risks associated with people's health, safety and welfare. Guidance and instructions were in place so staff had the information on the actions they should take to help mitigate risks and improve people's health. For example, an assessment of a person's pressure sore care was completed as soon as they moved into the home and there was clear evidence of the actions that staff had taken to minimise the risk to their skin integrity. A health practitioner explained if a person required pressure sore care the provider identified and acted on this quickly, which also included informing the chef to ensure that appropriate nutrition and hydration was provided and monitored to promote effective skin healing.

One person's care records showed how they were supported with their mobility. They were anxious about falling and needed reassurance and the support of two staff. The physiotherapist we spoke with gave us examples of the wide range of services available for people and the assessments undertaken to reduce the risk of falls. This included a wheelchair seating service and checks to assess staff were using hoisting equipment safely. Staff followed advice about safely maintaining people's mobility and encouraged people to exercise and take regular walks. The physiotherapist was complimentary about the swift action the provider took to source the correct equipment when this was needed.

There were sufficient numbers of suitable staff to support people to stay safe and meet their needs. Background checks were undertaken before staff were employed by the provider. Staff files held up to date information such as proof of their identification, an application form, criminal record checks and right to work in the United Kingdom. Job descriptions were signed by staff to show they understood the responsibilities of their role. Verification checks on nurses had been obtained through the Nursing and Midwifery Council (NMC). The NMC maintains a register of all nurses, midwives and specialist community public health nurses eligible to practise within the UK.References were sought from staff's previous

employers, however we found for two members of staff their references had not been authenticated. The registered manager agreed to follow this up with their administrator.

Staffing levels had been assessed to ensure there was enough staff on duty to provide safe and effective care for people. There was a two to one staff ratio to support people with their needs and we observed that care provided for people was unhurried and they did not have to wait for support. Staff explained this was beneficial to people particularly if they required more intensive support, for example with their mobility and personal care needs or being accompanied in the community.

Staff supported people to take their medicines safely and in a way that was right for them. People were given their medicines as prescribed and time critical medicines were administered appropriately. For example, one person was administered medicines for Parkinson's disease so it was important that they received their medicines at exact times for this to be effective. A relative commented, "In regards to [my family member's] medication, since being here she/he is more regular and stable, health wise."

Protocols were in place to ensure the safe use of medicines. Records showed the type of medicines people were prescribed, how they were administered and when people had taken their medicines. There was a clear policy for homely remedies that required staff to let the GP know if homely remedies were administered three consecutive times so that the GP could review the person's medical and medicines needs. The disposal of medicines was clearly documented when these were no longer required. Medicines were stored securely in the treatment room and within the recommended temperatures. This demonstrated the provider ensured the proper and safe management of medicines.

People's safety was maintained through the maintenance and monitoring of systems, equipment and infection control. Certified external contractors carried out servicing on fire, gas, water and medical equipment. Fire safety procedures were adhered to and people had individual written plans on how they should be supported when leaving the home in the event of a fire. For example, one person's personal evacuation plan was bespoke to meet their needs and documented the type of support they would need because of their hearing impairment.

All areas of the home were immaculately clean and free from malodours. Staff wore personal protective equipment such as aprons and gloves when this was required to reduce the risk of infection or illness due to poor hygiene practices. Waste disposal facilities and arrangements for clinical waste disposal were safely managed and records showed that staff had completed infection control training.

The provider had outsourced a specialised laundry service that collected people's laundry on a regular basis and people were given the option of having their clothes dry cleaned. People were provided with laundry bags that were bar coded to people's name and 'suite' so their personal belongings would not be misplaced. Rooms were regularly cleaned and in addition to this housekeeping services were available for people who chose to have their room spring cleaned.

Accidents and incidents were recorded and reviewed and discussed at meetings to inform clinical governance and use as lessons learned.

Good

Is the service effective?

Our findings

People's individual needs were met by the adaptation, design and decoration of the premises. The home had been designed to move away from looking like a traditional nursing home and was designed to look like a high quality hotel. A visitor of a person who used the service commented, "The care home is like a hotel. [My friend] has [their] own en suite and the food is amazing." We spoke with the designer of the building who explained they had designed many hotels but their purpose was to strive to make the structure of the building specifically for people with dementia, and told us of their future plans for the home. We were informed that people using the service were familiar "with levels of hospitality as many people had travelled extensively and lived in hotels."

There was a video intercom system at the entrance to the service and there was a long communal hallway on the ground floor that led to the lift. On exiting the lift we were met by a concierge and receptionist who greeted us warmly and led us into a central atrium which held a piano and comfortable and relaxing seating areas where people could socialise relax and eat. There was an open gallery brasserie (kitchen) where we could see the chef busy preparing meals. There was 'guest services' to help with the evening meals and the concierge explained they had worked in a well-known luxury hotel in central London and held a degree in hospitality. Room service was available for people who wished to have their meals in their 'suites'. During the tour we viewed the sunroom and indoor garden which provided a bright, open and spacious area. There was a snug library, quiet room, a spa and hair salon where people could have their hair, beauty and nails done on a Saturday.

The doors to people's suites were painted white with a grey door frame. Door plates showed the number of people's suites and were highlighted in primary colours to help people with visual impairments and/or dementia to easily identify their rooms. In addition to this, personalised name plates were displayed next to people's suites and painted the same colour as the door plates. Some name plates were painted red to help people with orientation to their rooms. We viewed two people's suites that displayed the items they cherished and displayed memorabilia of their personal achievements and photographs with their significant others. One person's room held a stack of suitcases and the deputy manager explained this was important to the person to give them the sense they were staying in a hotel as opposed to staying in a nursing home

There was a unique 'hotel' dining experience for people who used the service. People were given the choice to have their meals when they wished. There were no set times for meals, for example, records showed that one person chose to have their meals late at night as this was what they were used to as part of their lifestyle when living in their own home. During the meal we observed the menu was displayed in the communal area and showed the starter, main meal and dessert that was being served and the dining tables were attractively laid. People were offered a choice of refreshments with their meals including wine. We observed a lunchtime meal and saw that one person was served by an appropriately dressed head waiter and asked the person, "Can I get you anything else ma'am?" When the person asked for water this was served with waiters' etiquette, with one arm positioned behind their back as they poured water for the person.

Meals were beautifully presented by an award winning chef and every effort was made to make the dining

experience pleasurable for people. The starter which was well presented was brown homemade rye bread, crushed avocado with a poached egg on top and served on a dark red plate. The contrast of the foods colouring against the plate looked striking and reportedly supports people with dementia to eat more.

Two people required assistance to eat and staff did this gently engaging people in conversation. Staff were encouraged to eat meals with people and could choose foods from the menu or could access snacks for the entire time they were on duty if they preferred a different option. Alerts showed up on people's electronic care plan to remind staff about how much fluid people had and if they were at risk of malnutrition. For one person their records showed they had fortified meals, did not have any specific food requirements and was able to make their own choice about their preferred options for meal times.

The chef explained how they had won 'chef of the year' with their previous employer and had the freedom to purchase organic and fresh groceries from local shops. They showed us examples of the fresh foods they cooked and told us about people's dietary needs. A relative commented, "[My family member] insists on the same sticky ice-cream every day, no matter what." There was a list displayed in the kitchen of people's specific nutritional needs and food items were prepared, sealed and stored in a clean kitchen.

People's needs and choices were assessed and care, treatment and support delivered to achieve effective outcomes. People and their relatives told us staff cared for them in the way they wanted them to. One person commented, "I come into the lounge from my room and they will already have a coffee the way I like it prepared for me" and a relative said, "Amazingly so. They seem to have gelled with [her/him]."

The provider used new technology to ensure people's overall care and support needs were regularly reviewed. Care plans were held on the provider's electronic system and the information about people's needs was recorded 'live'. Staff had access to an electronic app in a hand held device which they completed each time they provided care and support to people. For example, each time people were supported to have a drink or were turned and positioned this was recorded electronically. Registered nurses also had access to record and update their nursing interventions. There were live recordings of activities people had attended on the inspection day. For example, we could see where a person had joined a reading group followed by attendance at a reminiscence group. This meant that people's overall care needs were captured as soon as care was provided to ensure that staff could be responsive to their changing needs.

People were supported by staff who had access to the training and support they needed to carry out their role. This included an induction and training to enable them to meet the needs of people using the service, for example, dementia awareness, mental capacity and the Deprivation of Liberty Safeguards. Records demonstrated the required training was completed by staff such as moving and handling, record keeping and care planning, first aid, health and safety and food hygiene. Staff told us they received regular supervisions and used this time to identify and address any learning and development needs to support them in their role. The registered manager explained that appraisals were due to be completed as the service had been opened for a year.

People were supported to live healthier lives and had access to healthcare services. One person told us they were visited by the GP frequently and a relative commented, "I have met with the GP and held a detailed discussion about a scan and [my family members] dementia."

Records highlighted that staff worked closely with a wider multi-disciplinary team of healthcare professionals to offer advice and treatment about people's healthcare needs. The provider used established clinical assessment tools to monitor people's ongoing healthcare needs, for example, the Abbey pain scale for people with dementia, the Braden scale to check people's dependency and the Cornell scale to assess

people's level of depression. The GP explained the provider had a dedicated team at their practice and people were given the choice of registering with the practice, or remaining with their own GP if possible. They visited people weekly and saw everyone in the home and spoke highly of the staff who followed their instructions "to the letter". A model of care was set up to create a clear pathway of treatment comprising of a full dementia assessment by the psychiatrist including being assessed by the head of memory services if further treatment was needed. People's health records held at the service were accessed electronically by the GP who added their own notes after giving advice or when visiting people in the home.

Consent to care and treatment was sought in line with legislation and guidance. 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. 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 are called the Deprivation of Liberty Safeguards (DoLS).

People's capacity had been assessed to check their ability to make decisions about aspects of their care. Where best interests decisions were made about people's day to day care this was done in consultation with their relatives, spouses and health practitioners involved with their care. A DoLS tracker showed eight people's applications had been approved where they required 24 hour supervision in and outside the home. Where one person did not have any relatives an Independent Mental Capacity Advocate had been sought to support them with their decisions. Care records evidenced if people's significant other or relatives had the authority to make decisions about their health and/or welfare.

Good

Is the service caring?

Our findings

People, their relatives and visitors told us staff were friendly and caring. One person said, "[The staff] are always there to have a conversation with me." Their relatives commented, "Yes they are caring. I fully admire them for it. I am not sure I could handle it. They are very good at calming [my family member] when [they] mention [they] want to go home" and "Yes, but I can only talk about the day staff." A person's visitor commented "My perception is [the staff] are very friendly. I believe she/he goes out for a walk each day."

People's relatives and their visitors were warmly welcomed by staff and a visitor explained, "We pop in unannounced like the Care Quality Commission. We ring the bell and we are invited in and made to feel very welcome." The consultant psychiatrist told us that the care was extraordinary with an emphasis placed on person centred care. Written compliments that had been left by family members about the good care provided and they stated they would recommend the service.

Staff took an active interest in people's well-being and had a very good understanding of people's needs. Support was offered in a calm and considerate way and people were open and trusting of the staff that supported them. They were patient with people and took time to listen to what people had to say. During the late afternoon, we heard lots of laughter and frequent interaction between people and staff which made the environment feel inviting.

People were given the freedom to live their lives as they chose and were actively involved in the decisions about their care. One person said, "There is no prescribed time to get up." A relative commented, "[My family member] does what [they] want, sometimes gets up early, other times not."

People expressed their ideas and their views about how the service could improve during 'member and committee' meetings and these were listened to and acted on. Discussions were held about the choice of foods, suggestions for day time activities and the design of the home. For example, people had asked the provider for a weather barometer and this was purchased as requested. Records showed that where people described the food as 'excellent' and 'remains good'. They had made suggestions to attend day trips to London Aquarium; to participate in watching tennis in Wimbledon and for an area of the home to be turned into a quiet room where they could play bridge.

Staff were respectful of people's cultural and diverse needs and had completed equality and diversity training. Equality laws exist to identify, tackle and put an end to unlawful discrimination, to help improve workplace cultures and behaviours. Records showed that where people requested to be supported by staff of the same or opposite genders their needs were met. For example, there was clear guidance for a person about their catheter care and the deputy manager was trained to do male catheterisation as instructed by the GP. Another person's care notes showed that they spoke English but chose to speak a different European language, had no preference about the gender of staff they were supported by and liked to have half a glass of wine with their supper.

People were elegantly and very smartly dressed, their hair and nails well groomed and staff explained that

people were supported to pick and choose the clothes they wanted to wear each day.

People's privacy was respected and staff sought the permission of people before they entered their rooms. We observed staff asking people what they wanted before they supported them with their care. Staff told us they respected people's privacy and dignity by making certain people's doors were closed when supporting them with personal care. People accessed the community to partake in their leisure pursuits with the support of a member of the staff team or a relative and during the course of our inspection we saw several people accompanied to go out and to pursue their social interests.

People were given a 'members guide' about the facilities and what the provider had to offer. This included information about confidentiality, the nurse call system and the responsibilities of caring for people's pets. However we noted that information such as care records, menus and other information was not available in an easy read format to help people understand the care services available to them. We recommend the provider updates their information in accordance with the Accessible Information Standard to ensure people are provided with information they can easily read.

Good

Is the service responsive?

Our findings

People were supported with their interests, pursuits and activities that focused on person centred care. They commented, "The newspaper reviews I do, as well as assist in flower arranging for the lounge flowers" and "I go out with the care worker." A relative said, "My [family member] participates as [they] want. Much better than being alone in [their] apartment. [My family member] has been doing arts, going to the theatre, cinema, horse racing and walks in the gardens. One of the reasons for putting [my family member] here was mental stimulation and there is lots of it here. Super."

There was a bespoke timetable developed for activities and events and well thought out ideas for people to participate in. This comprised activities such exercise, outings, and group discussions such as armchair ballet, let's go fly a kite, swing time, zumba and Chelsea Court Place cinema presents. The activity coordinator commented, "We took them out to the screening of High Society at the Royal Albert Hall, we go out often."

We were informed the day usually began with a newspaper reading group and discussion about the daily news, which was hosted by one of the activity coordinators. Prior to lunch being served we observed the activities being undertaken in the library. There was a weekly timetable developed for activities. We observed the newspaper reading group and the quiz. The activity coordinator was reading aloud from the daily newspaper covering various topics from politics to the use of gendered language in schools and everything else in between. During and at the end of the articles she gave time for people to comment, discuss and present their own views. The activity coordinator listened patiently to ensure each person's views were heard and discussed.

The quiz was very interactive, thought provoking and attended by several people. The activity coordinator read out quotes to people leaving out the last word for them to guess. Some examples of this were, bet your bottom dollar; pot calling the kettle black; every dog has it's day and keep a civil tongue in your head. Some people got the answers right and some wrong but each answer was then gently discussed with people to make clear as to what each phrase meant. We observed that people were engaged and enjoying the activities.

There was a thorough assessment of people's needs This was carried out in collaboration with people, their relatives and a multi-disciplinary team to ensure that the provider had detailed information in order to make a decision about whether or not they could meet people's individual needs. Care plans made reference to people's health, lifestyle choices, significant others and their recreational pursuits. The podiatrist informed us that staff followed their advice to keep people mobile and active and frequently contacted them by email if they needed further information or advice. They had worked in healthcare for many years and thought the care people received was "extraordinary". They further added the difference they had seen in people's mental health and wellbeing in comparison to other services was "remarkable" due to the high level of staff interaction with people.

Advanced care wishes were written in people's care records on how people wished to be supported with

their end of life care needs. 'Do not attempt cardio pulmonary resuscitation' (DNACPR) instructions and evidence of discussions with health professionals and relatives were recorded. The provider was seeking to introduce the Gold Standards Framework (GSF) with a view to becoming GSF accredited. The GSF offers training for staff providing end of life care to ensure better experiences for people.

People told us they were able to raise complaints if they were dissatisfied with the service and were confident the provider listened and acted on complaints. Systems were in place for recording and managing any concerns people raised. The provider had received three complaints since the service opened and records demonstrated that action was taken to resolve these within the relevant timescale.

Good

Is the service well-led?

Our findings

People, their relatives and visitors expressed confidence in the registered manager's ability to run a good service. A person commented, "They are good. I have easy access to all [the staff]." And their relatives said, "I think we were amazingly lucky to get [my family member] in here and to afford it" and "It's wonderful, best thing I could have found." A visitor further explained, "It is an extremely pleasant and well run environment. [Person's name] is well looked after."

The provider held a day club which could be accessed by people who used the service and the wider public. Members of the public could be referred to the club following an assessment and payment of a member's fee, and included the provider organising a care plan, review and organised activities. These activities comprised of the chef leading interactive classes and giving demonstrations of meals, sensory stimulation for people's wellbeing, outings, art groups and reading materials. We observed the scheduled art session and spoke with the freelance illustrator who led the art project and undertook trips with members of the day club to galleries. Many of the members of the day club had previously worked in fashion, jewellery, and creative industries and we were informed that they continued to express themselves through the art workshop. We saw people's art work had been placed in the quiet room before being displayed for an art exhibition. A health practitioner explained how they had been invited to Chelsea Court Place one year anniversary event and commented positively about the facilities and the day club service.

Staff told us they were given the opportunity to share their ideas or express any concerns they had during team meetings and there was a cohesive approach to working as a team. They told us there was transparency and trust with the senior managers of the home and they were open to listening to their feedback. Their comments included, "I feel much more a part of a team at Chelsea Court Place. I'm not ignored; there is no conflict between us or outbursts between the team." The registered manager recognised the efforts of staff and purchased small gifts such as chocolates as a token of their appreciation.

Quality audits known as 'snapshots' were regularly completed to improve the standard and quality of care people received. These checked all aspects of finance and administration, people and their family members' involvement, infection control, restaurant service, personal care, the management of falls, leisure and recreational activities, laundry and maintenance. Relatives we spoke with told us they had participated in family meetings to discuss their family members' well-being and were kept informed on any new developments within the home. Surveys had been sent to people and their relatives in November 2017 and the provider was waiting for these to be returned to evaluate their feedback and learn from and implement change.

The provider was committed to working in partnership with other services. They participated in a research project called Beyond Words, which was being led by the University of Roehampton and aimed to use music to sustain language for people living with dementia. Relatives had been asked to sign consent forms for their family members to be part of the research project, where appropriate.

Plans were in place to improve service provision specifically aimed at people with dementia. The registered

manager spoke about introducing more specialised dementia training as a part the staff induction and a silent monitoring system to be used as part of the falls strategy programme. Electronic records were being updated so people's families could have access through a website portal and view their family members records to see their daily care records and activities people had participated in.