Bupa Care Homes (ANS) Limited

Canning Court Care Home

Inspection report

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21 October 2018

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 16 and 21 October 2018. Both days of the inspection visits were unannounced.

Canning Court is a purpose built home which is registered to provide residential and nursing care for up to 64 older people living with dementia. The home has two floors, a ground floor unit called Hamlet, and the first floor unit called Gower. Most people who lived at Canning Court had limited mobility and/or a diagnosis of dementia. At the time of our inspection there were 51 people living at Canning Court.

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

Canning Court is required to have a registered manager in post. 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 and associated Regulations about how the service is run. At the time of this inspection, this service did not have a registered manager in post. A new manager had been appointed and had been in post for four months. The new manager was in the process of completing their application for registration with the CQC when we visited.

We previously inspected the service in June 2017 and the rating after that inspection was 'good'. This inspection was prompted following concerns from local commissioners which included information related to people falling, a lack of permanent staff and poor record keeping. During our inspection visit we found there were areas where the provider needed to improve the service. We changed the rating of the service to 'Requires Improvement'. We identified a breach of the regulations and you can see what action we have asked the provider to take at the back of the full version of the report.

On the first day of our inspection visit there were enough staff to keep people safe. However, there were often occasions when staffing levels as identified by the manager based on people's assessed needs were not maintained, which impacted on the ability of staff to provide safe, responsive care. A lack of clarity around staffing levels meant senior staff were not aware of when they needed to follow the provider's policies to report low staffing levels in the home.

The provider had systems in place for auditing the service to monitor and identify trends and better respond to risks to people using the service, but these had not always been effective and had not consistently identified risks to people living at the home. The provider was working towards a quality improvement plan in response to the concerns that had been identified.

The provider had taken action to improve the management of identified risks to people's health and wellbeing. However, people in their bedrooms did not always have access to their call bells which put them

at risk.

Staff monitored people's health and referred them to other healthcare professionals if a need was identified. People received their medicines as prescribed and in accordance with good practice. The home was clean and tidy and staff followed good hygiene and infection control practices.

New staff had an induction into the home, however, the high turnover of staff meant the provider was constantly training new staff who needed time to gain the skills to provide effective care. Staff did not always feel supported but said their opportunity to speak to senior staff had improved recently.

People's consent was sought consistently by staff and the provider had made applications to the local authority for any restrictions that may be a deprivation of a person's liberty.

People were supported to eat and drink enough to maintain their health and staff were aware of those people who had been assessed as having risks around eating and drinking.

Permanent staff knew people well. They knew about their backgrounds and preferences and understood what was important to them. People received care from staff who were kind and caring and respectful and who understood how people's background and life experiences might impact on their emotions. When staff assisted people, they showed patience and understanding. However, staff felt their responsiveness to people's physical, social and emotional needs was inconsistent because they did not always have time.

The provider had improved the provision of activities in the home and there was more emphasis on providing meaningful engagement for people on a one to one basis.

The manager was still settling into their new role but felt confident because they had support from the provider to manage the changes needed to address issues and improve standards of care within the home.

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.

Staff rotas did not always reflect staffing numbers on each shift and people and staff raised concerns that fluctuations in staffing levels impacted on the care people received. Overall risks to people's health and wellbeing had been identified and were being managed, but further improvements were needed Following recent concerns that risks to people's wellbeing were not always managed, but improvements were still required in some areas to ensure people's safety. People received their medicines as prescribed and staff followed the provider's policies to protect people from the risks of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The high turnover of staff meant the provider was constantly training new staff who needed time to gain the skills to provide effective care. People's nutrition and hydration needs were met and staff were aware of people's risks around eating and drinking. Staff monitored people's health and referred them to other healthcare professionals if there was a change in their needs or abilities. Staff worked within the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who promoted their privacy and dignity. Staff supported people with patience and understanding and were aware of how people's background and life experiences might impact on their emotions. Staff respected people's individuality and took time to understand people's friendship circles so they could support people to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Permanent staff knew people's backgrounds and preferences and understood what was important to them. However, care staff did not always time to respond to people's individual needs to ensure their physical, social and emotional needs were met. The provision of activities had improved in the home, and people were encouraged to engage in activities that were meaningful to them.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had systems in place for auditing the service to monitor, identify trends and better respond to risks to people using the service, but these had not always been effective and had not consistently identified risks to people living at the home. improvement was needed to ensure staff followed the provider's policies and procedures. The provider was working towards a quality improvement plan and was looking at innovative ways to recruit and retain staff.

Canning Court Care Home

Detailed findings

Background to this inspection

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

This comprehensive inspection was prompted because of information we received from the local commissioners who were concerned about the quality and safety of the care and support people living at Canning Court were receiving. In response to these concerns the provider has been working closely with the local authority and in June 2018 voluntarily agreed to an embargo on the service accepting any new admissions to the home until further notice. The information shared with the CQC indicated potential concerns about staffing levels and the way risks were being managed. While we did not look at the circumstances of specific incidents during our inspection visit, we did look at associated risks.

The inspection visit took place on 16 October 2018 and was unannounced. The inspection team on the first day consisted of a lead inspector, two specialist advisors, a bank inspector and an assistant inspector. One of our specialist advisors was a registered nurse and the other was an occupational therapist. One inspector returned unannounced on 21 October 2018 to follow up concerns we had received around staffing levels at the weekend.

Before the inspection visit, we reviewed all the information we held about this service. This included previous inspection reports and notifications the provider is required by law to send us about events that happen within the service. We also looked at information received from the local authority commissioners. We used this information to inform the planning of the inspection visit.

As this was an inspection in response to concerns raised, we had not asked the provider to complete a Provider Information Collection (PIC). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We therefore gave the manager the opportunity to share this information during the inspection visit.

During our inspection visit we spoke with the manager and two regional support managers about their management of the home. We spoke with two nurses, one agency nurse, two team leaders, seven care staff, three activities co-ordinators, two housekeeping staff and a hostess about what it was like to work in the home.

During the inspection visit we spoke with five people who lived at the home and seven relatives/visitors. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

We reviewed ten people's care plans and daily records to see how their care and treatment was planned and delivered. We looked at three recruitment files, staff training records, records of complaints and reviewed the checks the manager and provider made to assure themselves people received a quality service.

Requires Improvement

Is the service safe?

Our findings

We previously inspected the service in June 2017 and the rating after that inspection for this key question was 'good'. At this inspection we found there were areas where the provider needed to improve the service and the rating for this key question has changed to 'Requires Improvement'.

We heard from local commissioners that there were several concerns as to people's safety prior to our inspection. The safety risks we were made aware of included information related to falls, lack of permanent staff, poor record keeping and issues in respect of the management of accidents within the home. We looked to see what improvements the provider had, or was planning to make at the time of our inspection, to ensure people living at the home were safe. We found the provider had made some improvements in line with visiting professionals' recommendations, but there were other areas that needed to be improved to maintain people's safety.

The provider's policies and procedures were not consistently followed to ensure there were enough staff working with the appropriate skills, qualifications and experience to meet their own identified staffing levels.

On the first day of our inspection visit there were enough staff to keep people safe. However, staff told us there were often occasions when staffing levels as identified by the manager based on people's assessed needs were not maintained, which impacted on their ability to provide safe, responsive care. One staff member told us, "There are enough staff sometimes, but they do have lots of half days downstairs and they're making staff from upstairs go downstairs in the afternoon and that makes us short up here. That puts pressure on the staffing upstairs and things can become unsafe. Even if there are only a few staff on the floor, things can be safe if we've got a good team, but it's always better to have the right numbers." When we asked another staff member how low staffing levels impacted on people they responded, "There is not enough staff to be with all the residents. If two (staff) are in the room changing someone, there is no one on the floor. I feel I cannot give the care that I want to sometimes through the day. The care staff are good, but there are not enough staff to give care."

Relatives expressed similar concerns. When we asked one relative if there were sufficient numbers of staff they responded, "No, especially in the evenings there is a lack of staff." This person felt this did not impact on their family member when they were there but said, "The staff become run off their feet which could affect others." Another relative told us they felt they needed to visit during the evening to maintain oversight of the care their family member received.

The manager acknowledged the home had been through a challenging time and many nurses and care staff had recently left the service for a variety of reasons. They told us there were a significant number of staff vacancies, particularly for nurses, and due to difficulties recruiting to those roles, they were changing the staffing structure within the home. Instead of two nurses on each floor, they were going to have one on each floor and a senior who was medication trained to lead the care staff. The manager told us they were actively recruiting, but in the meantime, they were heavily reliant on agency staff to cover shifts. They explained that to mitigate the risks of not having their own permanent staff, particularly nurses on the first floor unit, they

booked the same agency staff to ensure there was some consistency and continuity of care. However, we found last minute changes to agency staff allocated to the home, made it difficult to deploy staff to ensure an effective skill mix in all areas of the home.

The manager told us staffing levels were based on people's needs and abilities and they were confident one nurse and seven care staff on each floor was sufficient. Rotas confirmed it was planned the home was staffed to those levels, but rotas seen did not accord with the experiences of staff or relatives, especially in the evening and at weekends. We visited the home for a second day on a Sunday afternoon and found the provider's rota did not accurately reflect the number of staff on duty because two permanent staff and an agency member of staff on the rota were not at work. This meant the shift was operating with three care staff below the provider's own identified staffing levels. We asked staff on duty how this impacted on the safety of people in the home. One member of staff told us staffing levels were safe, "As long as nothing happens." Another raised concern about not being able to maintain observations of people who were at risk in communal areas and said, "I feel as if I am constantly chasing and I would like to be able to give more time to people." A relative did not feel their family member was unsafe, but said, "They can't get the quality of care if the staff aren't here."

Three people had been assessed as being at high risk of falling and as a result required one to one care. Staff told us it was difficult to maintain one to one support when staffing levels were lower than identified. At such times one staff member told us, "Our senior does medication as well as sitting with the person who is one to one. The one to one is supposed to be 12.00pm until 10.00pm, but we don't really manage it. We have to keep their bedroom door open and keep checking on them which is not safe at all."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We discussed our concerns with the manager who was unaware of the discrepancy between the rota and the actual number of staff within the home at the weekend. They told us senior staff had not followed the provider's procedures to manage unexpected staff absence and assured us this would be addressed through staff meetings and supervision.

Risks to people in their bedrooms were not always mitigated. Although people had call bells to call for assistance when they were in bed or in their bedrooms, when we checked two people who were being cared for in bed, both call bells had been hung out of their reach. One person told us, "It is up there somewhere. I've told them a hundred times, but they still put it up there." The other person said, "It is never in reach. Whenever anyone comes and does my bed they always put it out of the way and I can't get it at all."

Prior to our inspection visit we heard from the commissioners that there had been a concern about delayed access to healthcare following an accident. While we did not look at the circumstances of this specific incident during our inspection visit, we did look at how associated risks were now being managed. Clinical staff told us they now followed the provider's falls pathway which was clearly displayed in the nurses' station. Staff told us all falls were considered to have an associated head injury, and staff followed the provider's protocol for managing risks associated with such injuries. All records of falls were submitted for scrutiny by the manager to ensure appropriate action had been taken to manage any immediate risks and mitigate any further reoccurrence.

Some people were at risk of skin damage and we saw they had pressure relieving equipment and were regularly repositioned to alleviate pressure to vulnerable areas of their skin. A member of clinical staff told us care staff were trained to routinely check the condition of people's skin when providing personal care and

were good at reporting any concerns.

Our specialist nurse advisor checked the care records of two people who had tissue damage to their skin. Both people had a treatment plan and wound chart, however one person's wound plan contained conflicting information as to how often the dressing should be changed. We brought this to the attention of the regional support manager so they could clarify the instructions. Wounds were not consistently measured to support evaluation of the treatment plans, but regular photographs demonstrated they were improving which indicated the treatment plans were effective.

Some people could demonstrate anxiety or agitation because of their diagnosis. We looked at the records for one person who could demonstrate such behaviours. There was information in their care plan about how staff should respond when the person became anxious or agitated to ensure a consistent approach. Staff we spoke with demonstrated they knew this person well and the action they needed to take to support this person's mental wellbeing. Staff also recorded any incidents in a 'diary' to help identify any patterns or triggers, although this was not consistently accurate. For example, we identified one incident in the person's daily records which had not been included in their diary.

The provider had robust systems to identify report and act on signs or allegations of abuse or neglect. Staff had received safeguarding adults at risk training and were familiar with the different signs of abuse and neglect, and the appropriate action they should take immediately to report its occurrence. One staff member told us, "I would report anything untoward I noticed to a nurse or to the manager. If I needed to report anything outside of the home, I know there is a phone number on the noticeboard downstairs that I can use. BUPA staff also have a 'speak up' phone line and we have contacts for that on the noticeboard." Another staff member said they would report any concerns to the manager and added, "I know I can whistle blow if she does nothing. There is a copy of the whistleblowing policy in the nurses' station."

We found that when concerns had been raised, the manager had followed the provider's policies and procedures to mitigate risks and ensure people were protected from abuse and discrimination. However, we did identify one incident that had not been reported to the local authority safeguarding team in accordance with the provider's safeguarding responsibilities. We were assured this was an accidental omission, as other safeguarding concerns had been promptly reported as required.

The provider's staff recruitment procedures continued to be robust. Records indicated when an individual applied to become a member of staff, the provider carried out thorough checks around their suitability to work in adult social care. This included looking at their right to work in the UK, employment history, previous work experience, employment and character references and criminal records.

Medicines were managed and administered safely by trained staff and in accordance with best practice. Medicines were stored in a locked room, which was tidy, well organised and at the recommended temperature to ensure they remained effective. Everyone had an individual medicines administration record (MAR) with their photo and details of any allergies, to minimise the risk of errors. Records showed staff signed when people's medicines were administered and recorded when people declined to take their medicines. Where people were prescribed medicines on an 'as required' basis (PRN), guidelines were clear as to when these should be given. However, some people were on medicines that needed to be given 30 to 60 minutes before food or other medicines. The provider did not have consistent arrangements in place to ensure these specific administration instructions were followed.

Some people received their pain relieving medicines via a trans-dermal patch applied directly to their skin. It is important patches are rotated around the body in line with the prescribing instructions, to avoid people

experiencing unnecessary side effects such as skin irritation. Staff had recorded where patches had been applied to ensure people were protected from these risks. However, there was no record of daily checks to ensure the patches were still in place. Daily checks are important as patches can fall off or be removed by people, which could result in them experiencing unnecessary pain.

We checked covert medicines (medicines disguised in food or fluids for people who may not want to take their medicines to maintain their health and wellbeing). Records showed the decision to give people their medicines covertly had been a best interests decision with healthcare professionals and others involved in the person's care. The advice of a pharmacist had been sought to ensure that giving medicines this way did not impact on their effectiveness.

The provider's policies and procedures protected people from the risks of infection. The provider had issued guidance about how to keep the home clean and domestic staff had a checklist to ensure all areas of the home were regularly cleaned. Staff had received training in infection control and understood their role in relation to infection control and hygiene.

One person received their food and fluids through a PEG feeding tube directly into their stomach. There was a comprehensive care plan and guidelines for how this should be managed safely and to minimise the risks of infection.

A member of clinical staff explained that equipment was regularly checked to ensure it was clean and in good working order. For example, pressure relieving mattresses were checked daily to ensure they were working effectively, on the right setting to support people's weight and there was no damage which could lead to an increased risk of infection. However, we found the suction machine was not ready for use despite staff signing to confirm it had been checked weekly and was 'clean, the tubing attached and charged'. Our checks found the machine was not easily accessible, had not been charged and the tubing was not attached. The suction machine is an important piece of clinical equipment which should be immediately accessible as some people who lived in the home had swallowing difficulties and were at risk of choking.

Requires Improvement

Is the service effective?

Our findings

We previously inspected the service in June 2017 and the rating after that inspection for this key question was 'good'. At this inspection we found there were areas where the provider needed to improve the service and the rating for this key question has changed to 'Requires Improvement'.

The provider assessed people's needs before they moved to the home to ensure they could provide effective support and care. The manager told us that following recent challenges, they had refined the assessment process because previously some people had moved to the home who had complex needs the staff team could not always support. They explained that during the assessment process they now considered the skill sets of staff, and the needs of those people who already lived in the home. The manager told us some people who had been inappropriately placed, had moved to a service better equipped to meet their individual needs.

New staff received an induction when they started working in the home. One staff member explained, "When someone starts, they are linked with the senior carer who works with them for a week shadowing them, going through the paper work and making sure they get to know the care plans." However, the high turnover of staff meant the provider was constantly training new staff who needed time to gain the skills to provide effective care. One senior member of staff told us new staff needed time to translate their learning into every day practice, particularly when people became anxious or agitated due to their medical condition. They explained, "Some staff struggle to handle the confrontation. They don't do it in the best way because of their inexperience and then behaviours escalate."

People and relatives told us permanent staff were competent to meet people's care needs. However, they felt a high staff turnover and high agency usage impacted on the ability of permanent staff to provide effective care. One relative told us, "A lot (of staff) are really good but it is a shame on the high turnover. Most of the staff really know [name] and her needs." Another said, "It is saying there are enough staff for the staff here to be comfortable doing their job. If the staff are happy, the place runs like clockwork."

Staff told us their opportunities to have meetings with senior staff to discuss their work and training needs had improved over recent months. One staff member told us, "We are now having one to ones with our team leader and they do ask what we want and what we think needs improving."

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).

When people had a health condition that had the potential to impact on their decision making ability, MCA

assessments for specific decisions had been carried out. Staff demonstrated a good understanding of capacity and told us that by knowing people well, they could assist them to make as many of their own decisions as possible. When people could not verbalise their choices, staff told us they monitored people's non-verbal responses to support decision making. Where people did not have capacity to make every day choices, staff supported people in the person's 'best interests'. One staff member explained, "You should always assume they have capacity and a bad decision is not a wrong decision. If we do have to make a best interest decision, we will look at their past and what they like. You also get to know body language as well."

Staff understood the importance of promoting people's rights and gaining people's consent before supporting them. For example, at lunch time staff asked people if they would like a clothes protector rather than just putting one on them. One member of staff went to a person's room to get their supplementary records which were kept there. The staff member asked the person's permission before removing them. Daily notes demonstrated that consent was sought before personal care was given.

Where it had been assessed that people had restrictions within their care plans which they did not have capacity to consent to, an application had been made for the legal authority to deprive them of their liberty.

People's nutrition and hydration needs were met. People had access to food and drink throughout the day and night and could choose what they had to eat. We observed lunch being served in two communal dining rooms. Tables were neatly laid and a choice of meals and drinks were available. When meals were served, staff explained what was on offer and showed people the plated choices so they had a visual prompt to help them choose. There were also picture menus to help people decide about their meals. Meals, including those that were softened or pureed, looked appetising, and gravy and seasoning were added after meals had been served. People were encouraged to eat their meals and where people needed assistance to eat, staff did this with dignity and focus on the person they were helping. This ensured people ate and drank enough, and enjoyed their meal at their own pace.

Mid-morning and mid-afternoon snacks were offered to people with a choice of drink. Staff encouraged and prompted people to finish their drinks to prevent the risk of them becoming dehydrated.

Staff were aware when had been assessed as having risks around eating and drinking. Information about individual risks was readily available on each unit so all staff, including new and agency staff, could easily refer to it before supporting people to eat or drink. For example, staff knew which people had their drinks thickened because they were at high risk of choking and which type of cup they needed to drink from. Where people were at risk of not eating and drinking enough, staff recorded how much food and fluids they had consumed and when they had declined to eat and drink. Fluid charts were regularly checked and when it was identified that a person had not had enough to drink, this was handed over to staff coming on shift so they could encourage and prompt the person to drink more to increase their fluid intake.

Staff supported people to maintain their health and wellbeing. Staff monitored people's health and referred them to other healthcare professionals if there was a change in their needs or abilities. For example, one person had been referred to their doctor for a medicine review because of a change in their behaviours.

However, we found some people would benefit from more therapeutic interventions to maintain their independence and mobility for as long as possible. One staff member also commented it was hard to get some people out of bed because of a lack of suitable seating and explained, "There are not enough suitable chairs so we have to rotate the residents so those that can and want to, can sit out for part of the day." We discussed this with the manager who assured us people were referred to the falls clinic for further advice and guidance when a need was identified, but that it often took time for the referrals to be processed.

The premises had been designed and decorated to support people to move easily from their own bedroom and around the communal areas of the home. There were several rooms and areas along each corridor where people could sit and rest or watch what was going on around them. Communal areas had different themes and offered people a choice of where they wanted to spend their time.

People had memory boxes outside their bedrooms to which they or their family, could choose to add personal items, to help them identify their own room. Toilets and bathrooms had brightly coloured doors and dementia friendly signs on them so people could easily identify them. Bedrooms provided people with their own private space and were large enough for staff to safely use equipment such as hoists.

There was a pleasant outside area people could spend time in on warmer days. For those people who were unable to go outside, or who preferred not to, one lounge had been turned into a garden room so people could still enjoy being surrounded by flowers and other objects associated with being outside. The manager told us some areas of the home were due to be refurbished to ensure people were provided with a homely but interesting environment to live in.

Good

Is the service caring?

Our findings

We previously inspected the service in June 2017 and the rating after that inspection for this key question was 'good'. At this latest inspection we found staff continued to have a caring approach and the rating remains 'good'.

People and relatives told us that staff were kind, thoughtful and compassionate in their approach and particularly spoke of their confidence in regular staff. One visitor told us, "It is incredible. You couldn't fault it, the staff are wonderful." Another relative told us, "The staff are dedicated and they are just lovely people. There is a warmth about the place."

Relationships and exchanges between staff and people living in the home were relaxed and comfortable. Staff, including non-care staff, interacted with people as they went about their tasks. For example, a maintenance person was mending a chair in a communal lounge and enjoyed some friendly 'banter' with all those present in the room. People's responses, demeanour and facial expressions showed they enjoyed this exchange.

When staff assisted people, they showed patience and understanding, and encouraged people and explained what was happening. For example, when giving a person their medicines, a staff member explained what the medicines were for and then took the opportunity to chat with the person while they were taking them. Staff communicated effectively with people and used different ways of enhancing that communication. For example, by touch, ensuring they were at eye level with those people who were seated, and altering the tone of their voice appropriately.

We saw that staff were aware of how people's background and life experiences might impact on their emotions. For example, a staff member asked people what they would like on the television. When people chose a particular film, the staff member checked with a colleague about one person's personal history to ensure it was suitable for them and would not cause any distress. Another member of staff told us about a person who needed to live in accordance with their preferred routines because of their military background. The staff member explained, "[Name] is very entrenched in military life and things have to be how they have to be for them or they will reject them." This staff member knew what was important to this person to make them feel comfortable and relaxed and went on to say, "They need staff that they trust to give them their medicines, and that staff member must always be wearing a medicines tabard."

Conversations between staff showed they genuinely cared about people and wanted the best for them. For example, on several occasions during the first day of our inspection visit we heard staff asking after a person and discussing the fact they appeared to be withdrawn and had chosen to stay in their bedroom. Staff were keen to have this person 'up and about' and engaging in their usual activities.

We saw dignity and respect was promoted by staff. People were clean, well presented and dressed according to their individual preferences, gender and culture. Staff consistently knocked on bedroom, or bathroom doors before entering.

The provider was committed to equal opportunities and diversity. Staff had received training in equality and diversity to support them in meeting people's individual needs and preferences. One staff member told us, "You respect their choices, this is how they have been leading their whole life and it is important to them."

Staff spoke respectfully about people as individuals and took time to understand their friendship circles so they could support people to maintain relationships with family and friends that were important to them. One visitor told us they rang every day to check on their friend and said, "Staff never mind me phoning."

Requires Improvement

Is the service responsive?

Our findings

We previously inspected the service in June 2017 and the rating after that inspection for this key question was 'good'. At this inspection we found there were areas where the provider needed to improve the service and the rating for this key question has changed to 'Requires Improvement'.

Care plans provided staff with information about how to meet people's needs. Each person had an individual care plan that was developed from an assessment of their needs, choices and capabilities. Care plans were detailed as to how staff were to offer individual and appropriate care and promote independence. Staff told us care plans were regularly reviewed and updated when a change in people's needs was identified.

Our conversations with permanent staff demonstrated they knew people well. They knew about their backgrounds and preferences and understood what was important to them. For example, we spoke with a number of staff about one of the people we had pathway tracked. They were consistent when talking about this person's personality, what caused them anxiety and how they preferred to spend their time.

Staff told us they could respond to changes in people's health and wellbeing because they were kept informed. One staff member explained, "We have a "take ten" every morning to bring everyone up to date with what's going on in the home and team meetings are arranged whenever we need them. There is also the handover document which is completed to make sure that everybody is brought up to speed with changes in the residents." One relative particularly commented on communication between staff and said, "They communicate well. As [name] has an irregular sleep pattern the staff tell each other how she has been each day so they know if she will sleep in longer on some days."

However. during our inspection visit staff raised concerns that staffing levels were regularly not achieved because of unplanned staff absence. Staff felt this impacted on the time they had to respond to people's individual needs to ensure their social and emotional needs were met. For example, staff told us they did not always have time to get people out of bed which could lead to them becoming frailer or socially isolated. One staff member told us, "When the (staffing) levels are low, people aren't got out of bed." Another said, "Much as we would love to, and do try, it is just impossible." Another commented, "We usually only get three or four residents up as we physically can't manage when short of staff or working with agency who don't know the residents."

Relatives expressed concern that pressures on staff time impacted on the social wellbeing of people, especially at the weekend. One relative commented, "I will come and there are only four or five care staff on. Basically it is run well, but there are not often staff sitting with people and talking to them…They are just basically left, some days [name] doesn't get up until 12.45pm because the staff are busy."

People and staff told us the opportunities to engage in activities in the home had improved and there were now four activities co-ordinators working seven days a week. One member of the activities team explained how they encouraged people to continue with their hobbies and interests to prompt memories and feelings

that were an important link to the past. They told us, "Some people enjoy music and singing and they have songs that they have enjoyed with their family. We try and write these down and remember them. Music is like magic with residents, it can be very quick to bring back people's memories and they join in." They went on to tell us, "We encourage people to continue with their hobbies. There's one person who used to enjoy knitting. She can't do it anymore, but she does enjoy it if we sit down and knit next to her and chat with her - it takes her back to her past." During the morning of our first visit we saw five people enjoyed a card game with an activities co-ordinator and some people were painting. On Sunday afternoon, people were sitting watching a film together. Other regular activities were the Canners Café on a Saturday morning and a pub lunch on Sundays to which families and friends were welcome. There were also weekly exercise classes to build up strength and encourage movement.

Activities staff told us they were working to improve activities for those people who were either cared for in bed or chose to stay in their bedroom. One activities co-ordinator told us, "If someone's bedbound, we might read to them. We might show them newspapers or show them pictures. You get to know the residents and what they like. There are some that can't speak very much so you can give them a massage or rub some cream into their hands. Just giving them some attention. For some people, they just like a hug, human contact is important." The activities team had implemented a spreadsheet to record people's activity and highlight those people who needed more attention. One member of care staff told us they had seen improvements and said, "It is getting better, they try and get to people in the rooms, a lot more imaginative and interaction."

People whose preference it was to stay in the home when they were very unwell, were given 'end of life' care. Care plans contained documentation that confirmed the person or their representative had been consulted about their wishes and an advanced plan stated how people wished to be supported at the end of their life.

Six complaints had been recorded in the nine months prior to our inspection. However, it was not always clear if complaints had been dealt with in line with the provider's policies and procedures because information about investigations and written responses were not always attached to the complaint. The manager could subsequently supply us with this information, but acknowledged the complaints file and log had not been kept up to date.

We received inconsistent responses when we asked relatives if they felt their concerns were addressed. Some people were very happy and one relative told us, "If I have something to say I will always say it. It's taken on board, I have noticed change if I have said things." However, we also received comments that indicated some people were not confident their concerns had been dealt with which meant they felt they had to maintain oversight of their family member's care.

Requires Improvement

Is the service well-led?

Our findings

We previously inspected the service in June 2017 and the rating after that inspection for this key question was 'good'. At this inspection we found there were areas where the provider needed to improve the service and the rating for this key question has changed to 'Requires Improvement'.

There was not a registered manager in post at the time of our inspection visit. The previous registered manager left in March 2018 and the deputy manager had been promoted to home manager. The new manager had submitted their application to become registered with us and was awaiting their 'fit person' interview at the time of our inspection visit.

The home had been through a challenging time due to significant staff shortages and some concerns around risk management. This had resulted in the provider agreeing with the local commissioning group that there should be a voluntary placement stop during which no more people would be admitted to the home. In response to these concerns, the provider had appointed a regional support manager to support the home. The regional support manager was a nurse and had experience of supporting homes which were not achieving the required standards. The manager told us they were still learning some of the responsibilities of their role but now felt more confident because they had support to manage the changes needed to address the issues identified. The provider's area manager assured us the regional support manager would continue to support the manager until the issues had been fully resolved, new staff had been recruited and people consistently received a good standard of care.

The provider had systems for auditing the service to monitor, identify trends and better respond to risks to people using the service, but these had not always been effective and had not consistently identified risks to people living at the home. Following audits by the local commissioners, there were several areas where the service needed to improve that had not previously been identified by the provider. People had been at risk because the provider had failed to identify shortfalls in the safety and quality of the service they provided. The provider is required to robustly audit the service, identify shortcomings, and comply with legal requirements.

Communication between managers and staff needed to improve to ensure people received safe, effective care that was responsive to their needs. Staff told us some of the issues around poor communication were because supervisions with senior staff and staff meetings had not been regularly happening.

One of the major issues impacting on staff wellbeing was unplanned absence by staff and a lack of clarity around staff numbers on each shift. When we visited on Sunday afternoon, the number of staff in the building did not accord with the provider's own rota and their identified staffing levels. The manager told us senior staff had not followed the provider's procedures for reporting low staffing levels so action could be taken. However, when we spoke with staff they told us they were not clear what the staffing levels should be. Comments included: "I don't know what the policy is….it's different every day", "Staffing levels do fluctuate, I don't know why. We can have five today and tomorrow six or seven" and, "We can be fully staffed in the morning and then two leave at 2.00pm and another two leave at 3.00pm." Staff told us they had raised

concerns about staffing levels but felt their concerns had not been listened to which impacted on their ability to maintain high standards of care.

Following our inspection visit the manager sent us a root cause analysis dated July 2018 which had been completed following an accident that had occurred in May 2018. Our evidence on the second day of our inspection was that the provider was still not following their own action plan to keep people safe.

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

The provider's area manager assured us the provider was acting to address staff recruitment and was developing innovative ways to recruit and retain staff. This included financial and travel incentives and a bus for staff who lived outside the local town. The provider had also recruited a clinical services manager who was due to start the week after our visit. They were to be supported by a senior nurse to increase the clinical support within the home. The manager was confident this extra level of clinical governance would underpin improvements in clinical care and risk management. However, they acknowledged the increased risks until they had their own team of nurses in place who were familiar with, and consistently worked within, the provider's policies and procedures.

Staff were open when speaking about the difficulties faced by the service over the last six months and how this had impacted on people and their own sense of wellbeing. One staff member told us, "Some days it's been horrible, but other days are really good. We've had a really good team in the past and we all got on really well. We need to get back there again." The provider's area manager had already started to address communication issues and held some meetings with staff, although these had not been recorded. One staff member said, "The only meetings we have had are with him. He does make you feel you can talk to him."

Whilst relatives spoke of the high turnover of staff and high agency usage impacting on the quality of care within the home, they expressed confidence that the home would improve once more staff had been recruited. Overall, relatives spoke positively about the new manager, but some expressed a view the manager should be more visible in the home, especially in the early evening when standards could drop.

The provider was working towards a quality improvement plan in response to the concerns that had been identified. This had driven improvements in a number of areas such as the provision of activities in the home, clinical oversight of those people identified as being most at risk and improved recording to confirm care had been delivered in accordance with people's care plans. Other essential daily, weekly and monthly checks to ensure the smooth running of the service and to identify any issues that could affect the standards of care within the home were being more consistently implemented. However, their own rating of the home in September 2018 recognised there were still areas where improvements were required.

People and relatives were invited to share their experiences of the service provided at Canning Court through a suggestion box in the reception area, an annual quality survey and regular meetings. The minutes of the last meetings demonstrated the provider had been transparent about the concerns raised and the actions being taken to address the issues.

The latest CQC inspection report rating was on display at the home and on their website. The display of the rating is a legal requirement, to inform people, those seeking information about the service and visitors of our judgments.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes to assess, monitor and improve the quality and safety of the service were not operated effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of suitably qualified and experienced staff available in accordance with their own identified staffing levels.