Premiere Health Limited

Cann House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 the 16 and 17 May 2017 and was unannounced.

Cann House provides nursing care and accommodation for up to 61 people. On the day of the inspection 51 people were living in the service. The service also provides assessment and rehabilitation to some people when they are discharged from hospital. This would normally be for a period of up to six weeks and is known as 'Discharge to Assess' (DTA) At the time of the inspection the service has 10 DTA beds, and seven were occupied. The assessment and rehabilitation of people staying in a DTA bed is overseen by a DTA team, which includes physiotherapists and occupational therapists.

At the last inspection on the 20, 21, 26 September 2016 we found significant concerns relating to medicines, risk, infection control, healthcare, privacy and dignity, care planning, complaints and leadership. We rated the service as inadequate overall. In line with our enforcement policy we made the decision to place conditions on the provider's registration. We told the provider they must send us monthly reports to tell us about their progress to address the concerns raised. This condition would remain in place until we are satisfied sufficient improvements have been made.

The service has also been in Special Measures. Services are placed in special measures when they have been rated as inadequate overall. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, the service is now out of special measures.

At the time of the September 2016 Inspection 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 person's'. Registered person's have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.The registered manager has now left the service and a new manager has been appointed. At the time of this inspection the new acting manager was in the process of registering with the Care Quality Commission. We have referred to this person as the 'acting manager' throughout the report.

Following the last inspection in September 2016 we requested that the provider sent us monthly reports on their progress to address areas of concern we had found. We received reports as requested and also met with the provider and Plymouth City Council to discuss the action taken to improve the quality and safety of services provided to people at Cann House. The quality monitoring team for Plymouth City Council told us the provider and acting manager had worked closely with them and had been open and responsive when discussing the concerns found and action needed.

People, relatives and other agencies said they had seen improvements in the service during the last six months. Comments included, "They are doing a good job", and "They have kept us updated and reassured

us that improvements are being made". The acting manager said they had spent time with staff discussing the concerns found at the last inspection and had considered what factors may have contributed to these failings. They said they had involved all the staff in these discussions and listened carefully to their views and feedback. The acting manager said they recognised the changes were work in progress, but felt positive progress had been made so far. Staff said improvements had been made and they felt more valued and involved in decisions about the service. Staff said they were very happy working in the home, and comments included, "Definite improvement since the new manager took over, morale is way up", and " There has been a change in the culture, we are working together as a team, everyone wants the service to improve and we are working together to do that, it is a joint responsibility".

At this inspection we found improvements had been made. The acting manager had prioritised areas they had considered to be of highest risk, and had addressed these within agreed timescales. They said they were aware further improvements were needed and were working closely with staff to embed some of the changes and working practice.

We found significant improvements had been made in relation to the management and administration of medicines. The acting manager and senior staff had been working with the supplying pharmacy and the CCG (Clinical Commissioning Group) medicines team to improve the way medicines were stored, administered and managed. We saw that there were still some problems with the supply of medicines and some improvements were still needed in the homes ordering systems to help further ensure people were safe and received the medicines they needed. The provider was aware of this issue and was in the process of taking action to address.

Improvements had been made in the risk assessment process, and we saw all risk assessments had been reviewed and updated. However, some risk assessments still needed further improvements when risks had been identified in relation to people's mental health and well- being.

People's care plans had been reviewed and most care plans we looked at included clear information about their needs and how they would be met. However, some plans still needed further improvement to help ensure the care provided was personalised and consistent. For example, one plan we looked at said the person needed "total support" in the bathroom, but did not describe how this care should be delivered. Although staff had good knowledge about this person's needs the absence of written records and guidelines could result in care being delivered inconsistently and not in a way the person chose and preferred.

People were assured a better quality of service due to the new quality assurance programme. Reviews had been undertaken of the homes quality auditing systems and improvements found in the service demonstrated these were now more effective. However, we found some gaps in care records relating to people's risks and some care records were not sufficiently personalised. These gaps had not been picked up by the homes quality monitoring processes and therefore required further improvement.

People said they felt safe living in the home and relatives said their loved ones were kept safe.Staff had updated safeguarding training and said they felt confident and competent to raise concerns if they felt people were at risk. The acting manager had spent time with staff empowering them to voice any concerns and information was available around the home about locally agreed safeguarding procedures.

People said they felt there were enough staff to keep them safe and said although there were busy times of the day call bells were nearly always answered in a timely manner. Staffing levels had been reviewed, and additional staff had been reruited where the need had been identified. The provider undertook a weekly audit of call bells and took action to address any concerns found.

People were protected by safe infection control practices. The home was found to be clean and well-maintained. Action had been taken to address concerns raised at the last inspection and this had included the fitting of key pads to the sluice room. This helped ensure people were protected from the risk of cross infection or by access to hazardous substances and equipment.

People's health and dietary needs were met. People had access to a range of healthcare professionals and the feedback from other agencies was positive. We were told the staff made relevant referrals and followed guidance and advice. Care records provided staff with good detail about people's healthcare needs and staff were familiar with this information. For example, skin care was well managed and records provided staff with clear instructions regarding dressing, wound development and progress. People said the food was of a good standard and they were offered choices when requested.

People were supported by staff who had the training and skills to meet their needs. New staff undertook a thorough induction before they started working in the home and then completed regular training relevant to their role and the needs of people they supported. Staff said they felt supported by their colleagues and management and were able to raise concerns and discuss issues about their practice.

Staff told us how they always asked people for their consent as they provided care, and we observed this in practice. Staff had received training on the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to access people's capacity to make certain decisions, at a certain time. When people had been assessed as not having the capacity to make a decision, a best interests decision was made, involving people who knew the person well and other professionals when relevant.

The atmosphere in the home throughout the two days was warm and friendly. We saw lots of caring and compassionate interactions between people and the staff supporting them. Staff told us they loved working in the home and greeted people with a smile and friendly conversation. The environment was bright and welcoming and information was available to let people know what was happening, such as menu's activity plans and community events. The activities co-ordinator had worked hard to provide a range of activities to meet people's specific needs and interests. As well as group activities, the activities co-ordinator and staff also spent one –one time with people chatting, reading books or partaking in a particular interest. The home had beautiful gardens, which people could easily access for walks and summer events. A chapel was also available, which people could use to attend mass, take communion or just use for quiet prayer and reflection.

People told us their privacy and dignity was promoted and respected. Comments included, "The staff always knock on my door before entering", and "The staff look after me well, keep me clean and always knock on my door". We saw staff knocking on people's doors and waiting before entering and 'Do Not disturb' signs were being used when personal care was being provided. Care records and staff meetings also provided prompts for staff about remembering the importance of promoting people's privacy and dignity at all times.

Following the last inspection the acting manager had undertaken a review of the homes complaints policy and procedure. They said discussion took place with the provider to consider the way complaints were handled to ensure people views were listened to, acted on and used to drive improvement across the service. We looked at two complaints that had been received by the provider since the last inspection. We saw these had been thoroughly investigated, with a written response sent to the complainant within the agreed timescales.

The provider had written to people and relatives about the findings of the inspection and the action they

would be taking to address the issues found. They had apologised to people about the failings and kept them updated of progress and improvements. This reflected the requirements of the Duty of Candour. The Duty of Candour is a legal obligation to act in an open and transparent way in relation to care and treatment and puts a responsibility on providers to promote the ethos of honesty, to learn from mistakes and admit when things have gone wrong.

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

Some aspects of the service required improvement to further ensure people were safe.

People with known risks associated with their behaviour did not always have sufficient support plans in place to reduce the risks and to keep them and others safe.

People's medicines were stored, administered and managed safely.

People were protected by staff who understood how to protect them from abuse and harm. People had confidence in the staff and felt safe when receiving support.

People were protected by safe infection control systems.

Staffing arrangements were sufficient to meet people's needs and to keep them safe.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the skills, training and support to meet their needs.

People were given the support they needed to make day to day decisions as well as important decisions about their lifestyle, health and well-being.

People were supported to enjoy their mealtime experience. People's specific dietary needs and particular likes and dislikes were known and understood by those preparing and providing meals and people were offered a choice of meals if requested.

People were supported to maintain good health and prompt action was taken to address any concerns or changes in people's healthcare needs.

Is the service caring?

Good

The service was caring.

People were treated with respect and dignity and their privacy was promoted.

People received support from staff who were compassionate and cared about their work and the support they provided.

People were provided with information and their views and choices were listened to and respected.

People were able to see and contact their relatives and others who mattered to them.

Is the service responsive?

Requires Improvement

Some aspects of the service required improvement to further ensure they remained responsive to people's needs.

People's care plans were not always sufficient in detail to ensure care was delivered consistently and in a way people needed and preferred.

People had access to a range of activities, which reflected their interests and needs.

People's concerns and complaints had been investigated thoroughly and used to drive improvement across the service.

Is the service well-led?

Requires Improvement

The leadership of the service had improved. However, these changes still needed to be embedded and built on to ensure people continue to receive a good quality service.

Gaps in records relating to risk and person centred care had not in all cases been picked up by the homes quality monitoring systems.

Prompt action had been taken to address concerns and improvements had been made within agreed timescales.

People had been kept informed of issues relating to the service and were reassured that progress was being made to make improvements and address failings that had been found.

Cann House 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 checked 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.

At the last inspection on the 20, 21, 26 September 2016, the service was rated as 'inadequate' overall, and was placed in 'Special Measures'. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe.

This inspection was carried out by two inspectors, a specialist advisor and a pharmacist. The specialist advisor was a registered nurse.

Before the inspection we reviewed information we held about the service. This included monthly reports we had asked the provider to send to us detailing the action they had taken and were taking following the last inspection. We also reviewed notifications sent to us by the provider. A notification is information about important events, which the service is required to send us by law.

During the inspection we spoke with 25 people who lived at Cann House, four relatives' relatives, the acting manager, registered provider and 12 members of staff. We also spoke with four healthcare professionals, which included an occupational therapist, and a physiotherapist.

We looked at a sample of records relating to people's needs. This included fourteen care records of people receiving nursing and non-nursing care, such as support plans, risk assessments and daily monitoring records. The pharmacist looked at all records relating to the management of medicines and also observed staff as they supported people to take their medicines.

Following the inspection we spoke with Plymouth City Council quality monitoring team who had been supporting the acting manager and provider to make improvements and a representative from the New Devon Clinical Commissioning team in relation to people supported in the home for a period of assessment following discharge from hospital.

We looked around the premises and observed how staff interacted and supported people. In addition to records relating to people's care we also viewed other records relating to the running of the service, including training records, quality audits and incident forms.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on the 20, 21, 26 September 2016, we found significant concerns in relation to people's safety. In all cases people did not have assessments and guidelines in place to mitigate risks associated with their care. Staff and management had not always acted promptly to address risk and to keep people safe. People's medicines were not stored, administered and managed safely. Staff did not always follow safe infection control procedures and staffing levels were not always sufficient to meet people's needs and to keep them safe. The service was rated as inadequate in this area.The provider sent us an action plan telling us how they intended to address these concerns and by when. We also told the provider they must send CQC a monthly report to tell us about their progress in addressing these concerns and improving the quality and safety of services provided to people.

At this inspection we found significant improvement in all areas, however, some improvement was still required in relation to the assessment and management of risk.

Some of the care records we looked at did not demonstrate sufficient action had been taken to reduce risks when they had been identified as part of the assessment process. For example, some people had been assessed as being at risk when they were in bed. As a result of this assessment bedrails had been fitted for some people. However, some people's bedrails had not been fitted correctly, leaving a gap between the mattress and bed/bedrail. This could increase the risk of people becoming trapped and/or injuring themselves. This was raised with the acting manager at the time of the inspection who said they would address as a matter of priority. The provider wrote to us the day after the inspection to tell us this had been addressed.

The risk assessments for two people stated that they were at high risk of displaying behaviours that may put them or others at risk. The risk assessments did not describe these behaviours or provide information on how they could be reduced or managed by staff supporting them. Although staff were very familiar with the needs of these people, the absence of this information could mean risks would not be monitored and managed consistently.

Risk assessments had been put in place and updated following the last inspection. Risk assessments were in place in relation to pressure care, falls and particular health conditions such as diabetes. In most cases the assessment described the risks and provided guidance for staff on how they needed to be monitored and reduced. For example, one person who had a pressure area identified had a clear plan of skin care and also had regular visits from the Tissue Viability nurse. Records provided staff with clear instructions regarding dressing, wound development and progress. Some people due to health conditions required oxygen, and risks associated with the use of oxygen were documented. This included the use of equipment and warning signs on the entrances to rooms where oxygen was being used.

We checked the way medicines were managed and administered to people to follow up on concerns found at our previous inspection. There had been lots of improvements made and the home had been working with the supplying pharmacy and the CCG (Clinical Commissioning Group) medicines team to improve the

way medicines were stored, administered and managed. An electronic recording system had been introduced for all people, and staff had received updated training on how to use this system. Medicines were stored securely and monitoring was now taking place to check that medicines were stored at the correct temperatures so that they would be safe and effective. There were suitable arrangements for storing and recording medicines requiring extra security. The medicine policy had been updated, and new auditing systems introduced. There were now daily, monthly and three monthly audits being completed and we saw that issues were picked up and systems put in place to address these.

The medicines we observed were being given to people at lunchtime in a safe person centred way. People were asked if they needed any medicines that had been prescribed for them on a 'when required' basis such as pain relief. No-one looked after all of their own medicines at the time of this inspection. However, there were policies in place to allow this if it was suitable and had been assessed as safe for them to do this.

We looked at the electronic medicine administration records (MAR) charts and the daily audits and found that staff were recording when doses were given or omitted for any reason. Separate records were kept for prescribed creams and other external preparations and these were completed by care staff when applied. Clear records were kept of medicines received into the home and those sent for disposal, which helped to check how medicines were managed in the home. All staff received updated medicines training and some had received competency checks to administer medicines safely. However at the time of inspection not all staff had been checked as competent. The provider showed us the new competency check form, which they said all staff would be completing as part of their on-going training programme.

We saw there were still some problems with the supply of medicines. Records for one person showed us they not received their strong pain relief for three doses the previous week due to lack of supplies. We saw that these had been ordered several times before and after they had run out. Another person had also missed several doses of pain relief over three days in the previous week due to lack of supplies. For both of these people alternative pain relief was prescribed and available, and we saw that extra doses had not been needed. Staff told us that there were sometimes delays in receiving supplies after they have been ordered and staff spent a lot of time chasing orders to check when they will be available. Staff had picked up this issue from the daily audits and we were told a new system had been drawn up with the supplying pharmacy, which the provider said should address this issue. This again reflected the ongoing work that the home is carrying out in conjunction with the GP practices, the supplying pharmacy and the CCG.

People told us they felt safe living at the service. Comments from people and relatives included, "Oh yes. I feel safe here, I feel safe with the staff", and […] is happy here and so safe, it is a relief for me knowing they are safe".

Since the last inspection staff had completed safeguarding training and had been provided with information about to raise concerns and protect people who may be at risk. Minutes of staff meetings confirmed safeguarding was regularly discussed as an agenda item. All staff said they had completed recent training and felt confident in the action they would take to protect and safeguard people they supported. The acting manager said their aim since the last inspection had been to empower staff to raise their own concerns by providing them with the information and training needed. Safeguarding procedures had been followed and action taken when people had been considered to be at risk of abuse and /or harm. People had information available to them about how to keep safe and what they needed to do if they felt unsafe or at risk of abuse.

People were protected by safe infection control practices. Steps had been taken to address the concerns we had found at the last inspection. For example, a key-pad system was fitted to the sluice room helping further ensure people were protected from the risks of infection. The sluice rooms were clean and well organised

and cleaning equipment had been stored safely. Equipment such as hoists and slings were found to be well-maintained and clean and slings were provided on an individual basis to help ensure they remained appropriate and available to the person needing them. Staff were observed wearing protective clothing such as aprons when providing personal care and followed best practice by not having nail varnish or wearing jewellery. Hand gel was available throughout the home, including the reception area and entrances to people's bedrooms and communal areas. Staff were seen using hand gel regularly as they provided care.

Staffing levels met people's needs and kept them safe. People said staff were available and call bells were mostly answered promptly, comments included, "It can be busy at breakfast time but mostly ok, they always make sure I have my call bell". Following the last inspection a full review had been undertaken of staffing numbers and skill mix. They said the review had looked at the needs of people being admitted, skills needed and staff responsibilities, along with times of the day when people required the most support. Additional nursing staff had been appointed, and the use of agency staff reduced. Daily handovers included a staffing allocation checklist, which helped ensure staff were situated and in sufficient numbers around the home. Staff said staffing levels were sufficient to keep people safe and to meet their needs. They said staffing had improved and were much clearer about their roles and responsibilities.

Good

Is the service effective?

Our findings

At the last inspection on the 20,21,26 September 2016, we found concerns relating to the monitoring and management of people's healthcare needs. The provider sent us an action plan telling us how they intended to address these concerns and by when. We also asked the provider to send us a monthly report to tell us about their progress in addressing the concerns we had found. At this inspection we found improvements had been made in the management and monitoring of people's healthcare needs.

People said their health needs were met by the service and staff supporting them. Comments included, "The staff look after my legs really well, so I have no pressure sores", and "I can see my GP whenever I want". Feedback from healthcare professionals was very positive, particularly in relation to the support provided to people following discharge from hospital. We were told staff made relevant referrals, were responsive to any suggestions and were good at listening and following guidance to support people's healthcare needs.

Care records in most cases provided staff with good detail about people's healthcare needs and staff were familiar with this information. For example, skin care was well managed and records provided staff with clear instructions regarding dressing, wound development and progress. It was noted that one person's plan lacked detail about the equipment used for oxygen. Staff were routinely changing the equipment each week as required, but this had not been detailed as part of the person's plan. This was raised with the acting manager during the inspection who acted to make sure the guidelines for staff were updated.

People's health needs were identified and addressed promptly. The health of each person was discussed at handover meetings, and any concerns, appointments, and particular monitoring arrangements were discussed and shared between the staff on duty and person in charge. Weekly meetings were held with staff and healthcare professionals to discuss people who were being supported following discharge from hospital. A GP visited the home each week and provided us with positive feedback about the service.

Staff were trained to meet people's needs and fulfil their role in the service. All new staff undertook a thorough induction programme, which included the completion of the Care Certificate for those staff who had never worked in care before. A training matrix was in place, which was used to identify training that had been completed and any that needed updating. Training was provided in a variety of ways, which the acting manager said was important due to staff's preferred ways of learning. Some training was available on-line and others face to face. Staff were provided with the time and facilities to complete what was required .Healthcare professionals provided training and support when required and training needs of staff were discussed in staff meetings, supervision and other regular meetings with healthcare professionals. This meant staff staff were kept up to date with current practice guidelines.

A senior member of staff was undertaking an advanced manual handling course, which would allow them to train staff in the home. The acting manager said this would be hugely beneficial as all new staff would be able to undertake manual handling training before they started work without the need to wait for external training providers. Another staff member had undertook nationally recognised training in end of life care and would be rolling this learning out to the staff team. All the staff we spoke with about training said they

felt they were supported to have the skills and training to meet people's needs effectively and safely.

Staff said they felt well supported by their colleagues, senior staff and management. A senior nurse was available to support nursing staff and to provide clinical training and guidance and a senior staff member was also in post to support the non-nursing care staff. The acting manager attended daily handovers and used this time to recognise any issues and where staff could require some additional support or guidance. An agency worker said, "I haven't been here for a while, I was given a full handover. It is a lovely place to come to and all staff are helpful and I can ask for assistance at any time". Formal supervision sessions took place for all staff every six to eight weeks and this provided staff with the time to discuss their role in the home, and any personal and practice issues.

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

Mental Capacity Act training was included in the homes training plan and staff demonstrated a good understanding of this topic. Capacity assessments were completed for people in relation to different aspects of their care and these had been documented and reviewed as part of the care plan process. Staff were aware of when people's capacity to make decisions could fluctuate and when they needed to consider best interest discussions. Care records also included consent forms in relation to people moving into the home, use of social media, and access to individual's records. Where people lacked capacity to consent to these arrangements family and other significant people had been involved in the decision making process. We observed staff asking for people's consent before providing care and treatment and using their knowledge of individuals to assess if people were happy with the care being provided.

The previous registered manager in post at the time of the last inspection had applied for Deprivation of Liberty Safeguards (DoLS) authorisations for some people in the service. People can only be deprived of their liberty in order to receive care and treatment, which is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes are called the Deprivation of Liberty Safeguards. Some of the applications had been authorised by the local designiated officer and some were still waiting approval. The new acting manager had reviewed the authorised applications to ensure practices in the home remained appropriate and had also chased up applications, which were still awaiting approval.

People's need for a balanced diet and to be hydrated were met. People had a range of needs in relation to mealtimes and diet. Some people were able to eat independently and chose where they wanted to eat their meals. Others needed assistance from staff and were either supported in their bedrooms or one of the two communal dining areas. The dining area was bright, with a sociable and friendly atmosphere. Staff were observed reminding those serving meals of people's particular preference in relation to portion size. When people changed their minds when the meals were being served the staff offered and alternative.

Kitchen staff were aware of people's specific dietary needs as well as likes and dislikes. This information had been documented in people's support plans and was also available in the kitchen for easy reference.

People said the food was of good quality and alternative choices were always available. Comments included, "Drinks are brought to us regularly" and, " Sometimes I get up late and they will always bring me

tea and biscuits, we get a choice of food if I don't like what's on offer"

Good

Is the service caring?

Our findings

At the last inspection on the 20, 21, 26 September 2016, we found people's privacy and dignity was not always promoted and respected. Some people told us they felt lonely and did not always feel valued and listened to. The provider sent us an action plan telling us how they intended to address these concerns and by when. We also asked the provider to send us a monthly report to tell us about their progress in addressing the concerns we had found. At this inspection we found improvements had been made.

People told us their privacy and dignity was promoted and respected. Comments included, "The staff always knock on my door before entering" and, "The staff look after me well, keep me clean and always knock on my door". We saw staff knocking on people's doors and waiting before entering and 'Do not disturb' signs were being used when personal care was being provided. Staff spoke respectfully and compassionately about the people they supported and said they always thought carefully about how to protect their privacy and dignity when providing intimate personal care. Care records also provided reminders and prompts about privacy, when detailing people's daily routines. Some people had requested female staff to support them with personal care needs. This information had been documented as part of people's support arrangements and people said their requests and wishes had been met.

People and relatives were mainly complimentary about the care provided by staff. Comments included, "Staff are very caring, they listen to you and have a joke with you" and "The care is very good, the staff are lovely", "Wonderful place, wonderful people" and "The staff do everything they can with a smile on their face". A few people said there were times when they felt a bit lonely in their rooms and didn't feel like they had seen anyone for a while. This seemed to be how some people felt particularly if their bedrooms were located at the end of corridors, where people and staff passing by was less frequent. We spoke with the acting manager about this at the time of the inspection and they said they would look at ways these people could feel less isolated.

Other agencies were positive about how caring the staff were in the home. Healthcare staff supporting people, who were staying in the home for a period of re-ablement prior to going home said they felt the staff really cared about helping people regain their independence. They said staff had supported one person who was very anxious by getting to know them and helping them regain their confidence.

Staff spoke with compassion about the people they supported. The home had a friendly warm atmosphere. We heard some lovely, friendly conversation between one person and the activities coordinator. They talked about different activities and what things they had both enjoyed. The person was very complimentary about the activities coordinator and said "She is an absolute gem!".. Staff smiled, and greeted people as they supported them or as they walked through the home. We saw one person wave and smile as a staff member entered the communal lounge and both asked each other if they were having a good day.

Staff readily provided information for people, telling them what was happening and why. This included telling people about visitors in the home as well as plans for the day such as meal- times and activities. People and relatives were also provided with a monthly newsletter so they had information about what was

happening in the home and future events.

We heard examples of when staff had gone that extra mile to make people happy and to demonstrate how much they cared. For example, one person had a particular passion for a local football team. The activities coordinator had arranged for one of the team members to visit and meet people in the home. They said as many people had grown up locally there were a number of local football supporters who were equally delighted with the visit.

Relatives were mainly positive about the service and the care their loved ones received. Comments included, "It has a family atmosphere. Our relative room is always kept clean and tidy", "We are always made to feel welcome, the care staff are lovely, wonderful" and "Always kept well informed". One relative did raise some concerns with us in relation to their loved ones care arrangements. These issues were passed to the acting manager at the time of the inspection. The acting manager was aware of the issues raised and was in the process of addressing them.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on the 20, 21, 26 September 2016, we found concerns relating to the planning of people's care. Care records were not personalised and did not provide staff with sufficient information to respond effectively and consistently to people's needs. We also found concerns relating to the complaint's process. Although the provider had a complaints system in place, they did not always listen to people, investigate their concerns thoroughly or consider ways to improve practice. Activities were available, but did not always take into account people's particular wishes or interests. The provider sent us an action plan telling us how they intended to address these concerns and by when. We also asked the provider to send us a monthly report to tell us about their progress in addressing the concerns we had found. At this inspection we found improvements were still needed in care planning.

Some care plans however, still lacked detail about people's needs and how they should be met. One plan stated the person needed "total support" with their personal care needs, but did not describe how this support should be delivered. Another person had some assistive technology in place to support them when they felt anxious. A device was fitted inside their bedroom with a relative's voice, which could be played to help them feel calm and less anxious. A staff member told us that although this was useful there were times when it also increased the person's anxiety. The use of the recording had not been documented as part of the person's plan, which could mean it would not be used consistently to benefit and support the person concerned. When we asked staff about these people they were able to tell us in detail about their needs and how they chose and preferred to be supported. However, the absence of clear, written information could mean care would not always be delivered consistently. We spoke with the acting manager about the care plans we had looked at and they said they would take action to ensure the detail was personalised and in sufficient detail. The provider sent an action plan the day after the inspection to confirm the care plans we had looked at were being updated.

The provider had told us that following the last inspection reviews had been completed of the care arrangements for all people living in the service. An audit had also been carried out of the homes electronic recording system to check and further ensure that information about people's needs were up to date and able to be accessed and understood by the staff providing care.

We looked at a sample of care records on the computerised recording system. This information included a summary of people's needs, including some background information and important contacts such as relatives and other agencies involved in their care. People's individual records also included a plan of care. Care plans are a tool used to inform and direct staff about people's health and social care needs. Our inspection in September 2016, found people's care plans did not ensure they received person centred care. At this inspection we found some improvements had been made. For example, there was good information about how people chose and preferred to be supported, one person's plan stated that they preferred a bath to a shower and staff needed to ensure they made bath time a relaxing and nice experience.

When we asked staff to tell us about people they were able to do so in detail. Computers were available around the home and staff were seen accessing and inputting information about people's needs and the care being provided. Staff were very familiar with this system and said they had good access to information about the people they supported. They said since the last inspection more hand held devices and computers had been made available, which had further ensured information was available and kept up to date. Weekly meetings also took place with staff and healthcare professionals to review the care being provided to people who had been admitted for a short period of assessment and rehabilitation. These meetings helped ensure people's needs were being met and that staff were following plans to enable people to meet their goals such as, to go home or move to a more independent setting.

Records confirmed systems were in place to review people's support arrangements and to amend information as people's need changed. People's care plans were reviewed monthly or when their needs or circumstances changed. In addition to formal review arrangements, daily handovers took place, which helped further ensure information and the care provided to people was appropriate and up to date.

Some people had been admitted for a period of assessment and rehabilitation following discharge from hospital. This process is called discharge to assess (DTA) and is supported by healthcare professionals within a DTA team. The DTA team met with the acting manager and staff weekly to review the progress of people in a DTA bed. We met the DTA team who were visiting on the day of the inspection and they provided positive feedback about the support provided by the provider and care staff. They said staff were very responsive and receptive to their advice and guidance, which had resulted in nearly all people being discharged home without further care being required.

People said the staff supported them in a way they chose and preferred and comments included, "I can't thank them enough. After two years they are getting me to walk again. It's great, I walked to the end of the corridor and back with another staff nearby with a wheelchair in case I fell". Relatives said the management and staff responded promptly to requests, for example "Any issues they resolve straight away [….] needed a longer bed as [….] is tall. They got one straight away".

Following the last inspection the acting manager had undertaken a review of the homes complaints policy and procedure. They said discussion took place with the provider to consider the way complaints were handled to help ensure people views were listened to, acted on and used to drive improvement across the service. We looked at two complaints that had been received by the provider since the last inspection. We saw these had been thoroughly investigated, with a written response sent to the complainant within the agreed timescales. The response by the provider demonstrated people's views and experiences had been listened to and taken seriously. Following the outcome of these complaints the acting manager had considered the issues raised across the whole service to help ensure people's experience of care remained positive. For example, an issue had been raised in relation to security in the home. The acting manager had investigated the complaint in relation to the person concerned, and had also used the findings to consider security and safety throughout the building.

An activities co-ordinator worked in the home five days each week. Their role was to help ensure people had access to a range of social opportunities. People spoke really highly of the activities co-ordinator and comments included, " They are the life and sole of the home", and "We get a list of activities given to us every week, I don't always want to go downstairs to join in but would give the activities coordinator ten out of ten". Information was gathered about people's likes and interests at the time of admission and this information was used to plan activities.

Information was available to people about a range of activities, which included group activities, such as

bingo, quizzes and gentle exercise, as well as one to one activities such as reading and manicures. The activities co-ordinator spent time with people who needed or chose to have care provided in their bedrooms as well as providing one to one activities such as hand and foot massages for people receiving end of life care. The home was situated within beautiful gardens and these were used for summer BBQs and outdoor activities including gardening.

We saw some people partaking in some group activities and the laughter and interactions we observed suggested people were enjoying being together and being active. We also saw staff spending time with people in their bedrooms doing individual activities including reading or just having a chat.

People's spiritual and religious needs were known and respected. The home had a chapel and people were able to use this facility when they wished to attend mass, take communion or just access for quiet prayer and reflection.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on the 20, 21, 26 September 2016, we found the service was not well-led. The rating for this area was found to be inadequate. The provider did not have an effective system in place to monitor the quality of care people received, and the impact on people's health and safety had not been monitored when new systems were introduced into the home. Staff said they did not feel supported or able to raise concerns, which they said had resulted in low morale and a negative impact on people who received care. The provider sent us an action plan telling us how they intended to address these concerns and by when. In line with our enforcement policy we made the decision to place conditions on the provider's registration. We told the provider they must send us monthly reports to tell us about their progress to address the concerns raised. The provider sent monthly reports as requested, detailing their immediate and on-going action to address the concerns we had found.

At this inspection we found significant improvements in the leadership of the service. The provider and acting manager had worked hard to address the concerns found at the last inspection. However, it was too early to judge if these improvements would be sustained.

This inspection found improvements had been made in relation to staff support and moral. Staff said they felt more listened to, were able to raise concerns and felt more valued. The new manager had worked hard to address the concerns found at the last inspection and quality monitoring systems had improved. Some further improvements were still needed to ensure the on-going quality and safety of the service.

Following the last inspection the acting manager had undertaken a review of the homes quality monitoring systems. This was in order to establish why failings had happened in the past. They said they believed roles and responsibilities of staff in relation to quality monitoring had not always been clear and this had led to the absence of sufficient checks and monitoring of the service. We were told that following the last inspection in September a number of audits were carried out with a particular focus on areas of concern such as, care plans, risk assessments and medicines. Senior staff had been appointed to undertake regular audits and auditing charts and timescales had been reviewed and agreed as part of the homes on-going quality monitoring system. The registered provider was also in the home regularly and working alongside the acting manager to monitor improvements.

Senior staff were clear about their role and responsibilities in relation to quality monitoring and had the time they needed to carry out the audits required. A large number of audits had been completed since the last inspection and the systems for monitoring the service improved. For example, a full audit had been carried out of medicines in the home and the senior nurse held responsibility for this area of care. As a result significant improvements had been made in the management and administration of medicines. Further improvement was needed but the areas affected were known to the senior nurse and were being addressed. However, the gaps in records, had not been picked up and addressed as part of the homes quality monitoring in respect of people's care records. For example, some of the risk assessments we looked at did not provide sufficient information for staff about how to mitigate risks that had been identified as part of the assessment process, and some care plans did not provide sufficient detail about how people chose and

preferred to be supported.

Improvements had been made in the organisation of people's records and information about people was stored safely and treated with confidence. The office areas were well organised so that staff could quickly and easily complete records and find relevant policies and procedures. Since the last inspection work areas for staff were improved and staff provided with the necessary equipment to complete records as required.Additional hand-held devices had been purchased and these were located around the building so that staff could update care records as required.

The acting manager had been in post for six months and was in the process of registering with the Care Quality Commission. They had been appointed soon after the inspection in 2016, and since that time had taken responsibility for addressing the concerns we had found. They told us they had previously worked in the home and believed the service could improve and continue to provide a good and safe service to people they supported. They had liaised closely with the local authority quality monitoring team to keep them updated on their progress in addressing concerns and also to seek advice and guidance when required. Feedback from the local authority was positive. We were told the acting manager and provider had been very 'open' and 'honest' and had demonstrated a willingness and determination to address the concerns and improve the services provided.

People, relatives and other agencies said they had seen improvements in the service during the last six months. Comments included, "They are doing a good job", and "They have kept us updated and reassured us that improvements are being made".

The acting manager said they had spent time with staff discussing the concerns found at the last inspection and considering what factors may have contributed to these failings. They had involved all the staff in these discussions and listened to their views and feedback. The acting manager said they recognised the changes were work in progress, but felt positive progress had been made so far. Staff said improvements had been made and they felt more valued and involved in decisions about the service. Staff said they were very happy working in the home, and comments included, "Definite improvement since the new manager took over, morale is way up", and " There has been a change in the culture, we are working together as a team, everyone wants the service to improve and we are working together to do that, it is a joint responsibility"

Staff were clear about their roles and responsibilities and all said this had improved since the last inspection. One senior member of staff said "I previously had so many tasks to do I was confused about my role". When we asked what had improved they said, "The management, the new manager", and "We have all had to learn, take responsibility, but with the new manager's support we have addressed things in an order and talked to each other all the time". Staff also said they felt the provider was also more involved and aware of the improvements that need to be made and why.

Staff said they felt well supported by management. Comments included, "We have good clinical support in relation to any nursing tasks", and "The manager for the home is always available and I also have my own line manager who I can go to about specific work issues and supervision".

The acting manager said they had aimed to empower staff to take responsibility and to raise concerns themselves if they felt it was necessary. A senior staff member said, "I think we are less complacent now, staff ask questions, they are not afraid to raise concerns".

Regular staff meetings were held, which allowed staff time to share experiences and reflect on practices. It

also provided a forum for management to share information and raise any particular issues or concerns about the service. We saw minutes of recent staff meetings, which demonstrated a wide range of topics were discussed including safeguarding, inspections and staff roles and responsibilities.

Residents' meetings took place and a monthly newsletter provided people and relatives with important information about the service. Feedback had been sought from people and their relatives and this information had been used to help improve the quality of the service. For example, a recent quality questionnaire had highlighted that meals were occasionally served late. As a result of the feedback the provider had recruited an additional mealtime assistant, which had resulted in improvements of mealtimes and service.

Following the last inspection the provider had written to people and relatives about the findings of the inspection and the action they would be taking to address the issues found. They had apologised to people about the failings and kept them updated of progress and improvements. This reflected the requirements of the Duty of Candour. The Duty of Candour is a legal obligation to act in an open and transparent way in relation to care and treatment and puts a responsibility on providers to promote the ethos of honesty, to learn from mistakes and admit when things have gone wrong.

We saw regular audits had been undertaken in relation to the environment, health and safety and accidents and incidents. The acting manager had introduced a falls flow chart, which described to staff the action needed if people had sustained a number of falls. The electronic falls audit provided a prompt for staff when a person had fallen, which ensured action was taken to address any particular issues. For example, one person had fallen on three occasions in one month. The audit prompted staff to make necessary referrals to the GP and well as to review the person's care plans and risk assessment to see if any changes could be made. The provider undertook a weekly call bell audit and records confirmed any delays in answering bells were raised with senior staff and explanations and actions documented.

At the end of the inspection we provided short feedback of what we had found. The day after the inspection the provider sent an action plan detailing how they intended to address any concerns we had raised. This would be asked for by CQC as part of the inspection process, however, the providers promptness further demonstrated their willingness and determination to improve the services provided to people living at Cann House.