CareQuality Commission

Bupa Care Homes (ANS) Limited

# Canning Court Care Home

## Inspection report

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Date of inspection visit:
06 June 2017
09 June 2017

Date of publication:
04 July 2017

Ratings

| Overall rating for this service | Good |
| --- | --- |

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

# Summary of findings

## Overall summary

We inspected this service on 6 and 9 June 2017. The inspection was unannounced.

Canning Court provides residential and nursing care to older people with dementia. It is a purpose built home which is registered to provide care for 64 people. the home has two floors, a ground floor unit called Hamlet, and the first floor unit called Gower. At the time of our inspection there were 61 people living at the home.

There was 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 2008 and associated Regulations about how the service is run.

This service was last inspected on 19 and 20 December 2016 and we found three breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. Procedures and processes to keep people safe were not always followed or effectively implemented, the deployment and management of staff did not ensure people who used the service were kept safe at all times and systems or processes were not robust, established and operated effectively to ensure people were consistently provided with a good quality service. We gave the home an overall rating of requires improvement. The provider sent us an action plan, setting out the actions they planned to take to improve the quality of the service. At this inspection we looked to see if the provider had responded to make the required improvements in the standard of care to meet the regulations. We found they had made improvements and they were no longer in breach of the regulations.

Since our previous inspection, the registered manager had recruited additional staff. There were enough suitably skilled and experienced staff on duty to meet people's care and support needs safely and effectively. Staff felt more confident because the management of shifts had improved.

People felt safe living at Canning Court. The process to report potential safeguarding incidents to ourselves and the local authority safeguarding team had improved. Risks to people's health and welfare had been assessed and care plans developed to minimise the identified risks. Staff understood how to support people identified as being at risk.

Staff had received training and felt this gave them the skills and knowledge they needed to effectively meet people's needs. Staff particularly felt they had benefited from training that had given them the opportunity to understand the sensory experiences of a person who lived with dementia.

Staff worked within the principles of the Mental Capacity Act 2005 when supporting people with personal care. They sought people's consent and respected the decisions they made. The registered manager had applied to the supervisory body when it had been assessed that people did not have the capacity to

understand the risks associated with any restrictions to their liberty.

People were supported to maintain a balanced diet according to their needs and to enjoy their meals. Staff monitored people's weight and nutritional intake and referred them to other health professionals if they had any concerns. People were supported to take their prescribed medicines by trained staff.

People were supported by kind and caring staff who demonstrated a commitment to want to care and enhance people's lives. Staff regularly worked with the same people so they knew them well and understood how they wanted to be cared for.

Care plans were detailed and reviewed regularly to ensure they met people's changing needs. Essential information was handed over between staff shifts so people's needs were met consistently and responsively.

People had opportunities to engage in activities that were of interest to them and improvements had been made in the social engagement with people who were cared for in bed.

There was a clear strategy to formalise leadership within the home. Staff felt more competent in their roles because they had confidence in the management team to provide leadership and support. Staff respected and appreciated the registered manager's leadership.

Quality audits included reviews of people's care plans and checks on medicines management and staff's practice. Where issues had been identified, improvement plans were implemented to ensure care was being delivered in accordance with the fundamental standards of care.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People told us they felt safe living at Canning Court. Improvements in staffing levels gave staff confidence they could meet people's needs safely and effectively. Potential risks to people's health were assessed. Staff knew people well and how to minimise their individual risks. The provider had a system of checks to ensure staff were recruited safely to the home. Medicines were managed safely and people received their prescribed medicines.

### Is the service effective?

Good

The service was effective.

Staff had the necessary skills, training and experience to carry out their role effectively. Staff worked within the principles of the Mental Capacity Act 2005, offering people choices and respecting the decisions they made. The registered manager understood the requirements of the Deprivation of Liberty Safeguards (DoLS). People were supported to eat a balanced diet to maintain their health. The provider worked in partnership with other health and social care professionals to support people's needs.

### 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's emotions, moods and anxieties with ease and demonstrated a calm and caring approach. Staff supported people at their preferred pace and knew the people they supported well.

### Is the service responsive?

Good

The service was responsive.

People's requests for support were responded to quickly by staff who had a good understanding of their needs. There was a handover of essential information between staff so they could

respond to people's needs in a consistent way. There were planned activities for people to take part in if they wished to and staff were aware of meeting people's social needs on a one to one basis.

## Is the service well-led?

**Good**

The service was well-led.

Since our last visit a strategy was to formalise and increase leadership within the home, which enabled the registered manager to focus on their managerial responsibilities. Staff felt competent in their roles because they had confidence in the management team to provide leadership and support. There was a schedule of checks and audits to ensure people received appropriate care and treatment. Changes were being implemented to improve the experiences of people who lived at Canning Court.

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# Canning Court Care Home

**Detailed findings**

## Background to this inspection

The inspection took place on 6 and  9 June 2017. The inspection visit was unannounced on 6 June 2017 and we told the registered manager we would return on 9 June 2017.

The inspection team consisted of three inspectors and an expert-by experience on the first day. An expert-by-experience is a person who has experience of using this type of service themselves or caring for someone who used this type of service. On the second day, one inspector returned to complete the inspection.

The provider had completed a provider information return (PIR) before our previous inspection, so we did not ask them to resubmit this information. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

Some people who lived at the home were not able to tell us about their experiences of living at the home due to their complex health conditions. We spent time in the communal areas of the home and observed the care and support they were given by staff.

We spoke with two people who lived at the home and seven relatives, who told us about their experiences of using the service. We spoke with staff on duty including two clinical services managers, four nurses, nine care staff, two activities co-ordinators, the registered manager and the operations manager. We also spoke with a visiting healthcare professional.

We reviewed a range of records; these included five care plans and a selection of medicine administration records. We looked at quality assurance audits and the results of the provider's quality monitoring system to see what actions were taken from people's feedback.

Good

# Is the service safe?

## Our findings

When we inspected Canning Court in December 2016 we identified the numbers and deployment of staff was not always sufficient to keep people safe, especially during the night. At this inspection we found the provider had taken the action they said they would take. They had recruited additional staff and improved the management of staff shifts. There were enough skilled and experienced staff on duty to meet people's needs and they were no longer in breach of the regulations.

People and relatives told us they felt safe in the home and well looked after. Comments included: "Oh good gracious yes, extremely safe", "I think she is quite safe" and, "I have no concerns at all (about safety) and I come every day."

We spoke with night staff in the morning before they went off duty. There was one nurse and four care staff on each floor and the atmosphere was relaxed and welcoming. All the night staff we spoke with told us staffing levels had improved following our last inspection visit. They told us night shifts were now covered by permanent staff which provided consistency because they knew people's needs, and gave them more confidence that they could meet people's needs safely and effectively. One staff member told us, "Staffing levels have increased. There are definitely more staff and we don't have agency anymore. I used to work with only agency and I would be the only permanent staff member on the floor. It was very difficult and very hard, but now we only have our own staff." Another staff member confirmed, "Before it used to be five or six care staff at night and now the minimum is seven which is much better."

The registered manager told us they had found leadership of the night shift was lacking. Since our last inspection they had made sure the night shifts were led by the nurses on duty and explained to nurses what the organisation's expectations of them were.

At our last visit we found there were sufficient numbers of staff during the day to meet people's needs. However, the deployment and management of staff meant there were times when there were not enough 'eyes and ears' to monitor people as they walked around the home and interacted with each other. At this visit we found improvements had been made.

Nursing staff, team leaders and care staff all told us staffing levels and the management of shifts had improved. Staff were now generally allocated to the same area of the home each day which gave them the opportunity to get to know people well and understand their individual risks. Nursing staff told us the increase in staff support meant people were safe because staff were on hand to support people, especially those at risk of falls or whose behaviours could be challenging to others. One member of nursing staff told us, "There have been major changes regarding staffing levels and the way things are done. Staff are now in the lounges and staffing levels have increased." We saw sufficient numbers of staff to meet people's needs. Interactions between staff and people were not rushed and people's requests for support were responded to.

Staff said there were odd occasions when staffing levels dropped below expected numbers, usually when

staff "rang in sick", but this did not happen often. One staff member explained, "The manager does allocate the right staff, but when staff don't turn up it's difficult, but they do try and get someone in as soon as possible."

At our last visit we found the layout of the building presented challenges as corridors and rooms were not always in view of staff and some people expressed concern that other people frequently walked into their bedrooms uninvited. At this visit we were told staff were required to have a presence in the lounge areas at all times, and we saw this happened. A member of staff in a quieter lounge seated themselves near to the entrance so they could also see most of the corridor. They supported people as they walked into the lounge to ensure they were seated safely.

During our visit there were still occasions when people who liked to explore their environment walked into other people's rooms. Staff knew who those people were, and generally had more time than previously to make regular checks on them. However, there was no formalised process as to when the checks should be completed to make sure people were not causing distress to others.

The registered manager had recently appointed a new clinical support manager so they now had one on each floor, instead of one for the whole home. This ensured there was always an appropriately skilled person to observe, monitor and manage the care team to ensure people's needs were met. One of the clinical service managers told us they were confident people now received safe care because they had, "Flexibility because of increased staff and we have a good mix of experienced and new staff."

We received some mixed comments from people and relatives about whether there were enough staff to meet people's needs. However, relatives confirmed they were aware of changes in the deployment of staff and their availability in communal areas. One relative said, "They made some changes and split the staff to each end of the unit so residents would see the same staff members." Another said, "I feel there is enough staff, it has increased recently. Staff didn't used to sit in the lounge with residents, they do now."

At our last inspection we found incidents between people who lived at the home had not always been reported to ourselves and the local authority safeguarding team as safeguarding issues. At this inspection we found improvements had been made in the process to record and report such incidents, but further improvements were still required. For example, it was recorded in one person's daily records they had entered another person's room and there had been a minor altercation resulting in a scratch to their face. This had not been recorded on an incident form and the registered manager was not aware of it so they could refer it to the safeguarding authorities as required. The registered manager assured us this would be addressed through supervision and staff meetings.

Staff told us they had training in safeguarding and protecting people from the risks of harm or abuse. The training made sure they understood the signs that could indicate a person was at risk of abuse. Staff told us they were confident to challenge poor practice and to share any concerns with the registered manager or senior staff. One staff member explained, "If I saw anything, I would tell the manager or report it to the police."

The registered manager assessed risks to people's health and welfare and wrote care plans to minimise the identified risks. The care plans were updated on a regular basis or when the person's needs changed.

Staff knew how to support people identified as being at risk. For example, some people were identified as displaying behaviours that challenged. Staff knew what actions to take to minimise potential behaviours from escalating. Staff knew to manage people's behaviours by distraction techniques, speaking in a calm

manner or seeking different staff to provide support. When behaviours did become challenging, the incidents were recorded to support any further interventions or referrals to other healthcare professionals.

Some people were assessed as being at high risk of falls and staff knew how to support people to limit the risk. One person had numerous falls and to reduce the risk they received one to one support from staff for 12 hours each day. The registered manager and staff told us this level of support had greatly reduced the number of falls the person had. Where people had been identified as requiring equipment to keep them safe, for example if they rolled out of bed, we saw this was in place.

Staff were recruited safely because the registered manager checked they were of good character before they started working at the home. The registered manager had obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. One staff member confirmed, "I had to have references, two or three, a DBS check and identification. I had to have them in place before I started."

People and relatives told us staff supported them to take their medicines. One relative told us, "They are quite good with medicine timing. I see them in the morning and at lunchtime." Another said, "[Person] takes three types of medicine once a day in the morning. It is regular."

Medicines were managed and administered safely and in accordance with best practice. Medicines were stored securely and at the recommended temperature to ensure they remained effective. Everyone had an individual medicines administration record (MAR) with their photo, 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.

Since our last visit, improvements had been made to ensure medicines were administered in accordance with people's prescriptions. There was guidance for nurses to ensure medicines were administered at the right time, when the time was specified in the prescription. For example, those medicines that needed to be given 30 to 60 minutes before food. There were written medicine plans (protocols) for people's 'as required' (PRN) medicines. Where people were not able to express or describe their pain, staff used a recognised pain assessment tool to assist them to identify when pain relief was required.

Where people were prescribed transdermal patches (patches which deliver medicines into the body via the skin), body maps showed where the patch had been applied. Patches were rotated on each application. This is good practice because skin can become irritated if the patch is applied in the same place.

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). We found individual MARs did not record how to administer the medicines covertly and safely. Speaking with the clinical support manager and staff who administered medicines, we found covert medicines were disguised using different methods, such as with water, in sandwiches or biscuits or yoghurt. Safe medicine guidance suggests pharmacist advice is recorded to show how to administer covert medicines safely, yet only one out of four people's records contained information from a pharmacist. At the end of the first day of our inspection visit, the registered manager had sought guidance from the pharmacist to ensure medicines continued to be administered consistently and safely.

Staff who gave people their medicines had received training and regular updates in the safe management and administration of medicines. Their competence to give medicines safely was regularly assessed.

Good

# Is the service effective?

## Our findings

People and relatives felt staff had the appropriate skills and knowledge to meet their needs effectively. Comments included: "Most of them are well trained", "They go on lots of courses" and, "I have no complaints about how she is handled."

Staff told us they had the necessary skills, training and experience to carry out their role effectively. New staff had an induction to the home which included training and observing and working alongside an experienced member of staff for a period of time. They also described how the provider supported them to obtain qualifications in health and social care. One staff member told us, "I had one week of training, spent one day observing and shadowed staff for three days. I felt ready to give care after this." Another said, "I was supernumerary (not on the rota) for three days.....I am now doing my NVQ in the dementia pathway."

The induction for new staff was linked to the Care Certificate which assesses staff against a specific set of standards. To receive the Care Certificate staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

There were improvements in staff's training and confidence since our last inspection visit. At that inspection the registered manager told us they felt staff would benefit from further training in dementia care. At this inspection visit we found staff had completed 'virtual dementia' training. This training provided staff with the sensory experiences of a person who lived with dementia so they could understand how it impacted on their everyday life. One staff member explained, "We were put in the place of a resident with dementia. We had to wear goggles and ear sets and things in our shoes to make our mobility uncomfortable. It was extremely interesting." Another said, "We were in their bodies and had all this equipment on with noises and sounds and gloves on and things in our shoes. We were put in a darkened room and asked to do some tasks. It certainly opened our eyes, it was really frightening to not be in control. We will never fully understand, but it gives you a better feel about their needs and how to talk to them."

All the staff felt the training had given them a valuable insight into the experiences of people who lived with dementia and how restrictive and confusing it was. They said it had added value to their practice and every day interactions with people. One staff member explained, "You have to be very patient with them. We try to make them feel as comfortable as they can and try and get into their world." During our visit we observed staff put their training into practice. They spoke quietly and calmly to people, and provided reassurance to people without devaluing what they were saying. They took time to listen and understand how people wanted to be supported. On one occasion we saw a staff member apologise when they pulled out a chair, knowing the noise might upset people.

Supervisions are meetings with a line manager which offer support, assurance and learning to help support workers develop in their role. Staff told us they had regular opportunities to meet with senior staff to talk about their work within the home. Clinical support managers also regularly observed staff to ensure they followed best practice and provided safe and effective care that was responsive to people's individual needs.

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 an assessment shows a person lacks 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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff told us they had regular training and understood the principles of the MCA. Staff told us they assumed people had capacity to make everyday decisions. Staff understood their responsibility to act in people's best interests when it had been identified the person lacked the capacity to make a specific decision. A member of staff told us they communicated well with relatives and GPs to make decisions in the best interest of the person. For example, where people did not understand the risks of refusing their medicines, best interest decisions had been taken by all those people involved in their care, that they should be given covertly.

Staff told us how they would manage situations where a person declined care. They said if a person became agitated and displayed behaviours which would challenge others, they would leave the person and go back later when they were more calm. They told us this approach usually worked.
One staff member explained, "We have a duty of care, so we talk, try and reason. We do this because it is in the persons 'best Interests'.

Staff recognised seeking consent from everybody was an important part of caring for people. Staff checked with people whether they wanted assistance before supporting them. For those people who were unable to communicate verbally, staff maintained eye contact and watched people's facial expressions or body language to understand whether they consented to support. During our visit we saw staff gave people choices, and respected their decisions when they declined. For example, we saw a member of staff ask one person if they would like a clothes protector when they had their meal. The person declined this offer and the member of staff immediately responded, "That's okay." A relative confirmed, "They have a policy that if [person] says no, they do what they tell them."

The registered manager had applied for a DoLS for 51 people who lived at the home, because they did not have the capacity to understand the risks associated with the restrictions to their liberty. At the time of our inspection, 18 DoLS applications had been agreed by the local supervisory board and the rest were being progressed by the local authority. Staff knowledge of people who had an approved DoLS was not always consistent. However, staff said most people in their care needed constant supervision to keep them safe, rather than to prevent people from exercising their choice.

People were given choices about their daily care and how they spent their day. At lunch time some people ate in the dining room, some people ate in the lounge and some people chose to eat in their bedroom. At breakfast people were given a choice of what they wanted to eat, including a cooked breakfast.

People were supported to maintain a balanced diet according to their needs and to enjoy their meals. The meal time was relaxed and staff were supportive and observant of those people who needed assistance. Staff sat beside people when assisting them and did not rush, allowing people sufficient time between each mouthful to enjoy the taste of their meals. Staff were very encouraging and aware of those people who were not eating and offered lots of choices and alternative options. People were positive about the food provided. Comments included: "The food here is excellent" and, "There is a choice at lunch time and they ask what she

wants."

People were offered snacks and drinks through the day. However, some people raised a concern that the mid-morning drinks were often delayed for people who were in their bedrooms. One relative explained, "I would say [person] gets a drink and biscuits at 12.00pm which is too late, it puts her off her lunch. This happens regularly because the person who does it also gives drinks to people who can't do it themselves." However, people confirmed that if they requested a drink, staff responded quickly.

Nursing staff used a recognised assessment tool to identify whether people were at risk of poor nutrition. People's care plans included a nutritional assessment and an appropriate care plan for those identified as at risk. Where people were identified as being at risk of not eating and drinking enough, they were on food and fluid charts to monitor their intake. The charts we reviewed were detailed and where people had refused food or drinks, this had been recorded. Each person's fluid intake was totalled and the charts were checked daily which ensured any risks were monitored so further action could be taken if necessary.

Staff regularly monitored people's weight and referred them to other health professionals, such as the speech and language therapists or dieticians if they had any concerns about a person's nutrition. This had improved since our last visit. One relative confirmed, "They were worried about [person's] BMI which was dangerously low. The nutritionist came last week and said to give [person] milky drinks. They don't like milk and wouldn't drink them so they then suggested fruit juice. [Staff member] rang me and told me what the nutritionist had said. I have no qualms with the staff at all."

Staff and people told us the provider worked in partnership with other health and social care professionals to support people's needs. Care files showed people's health care needs were being addressed by regular involvement of professionals such as, doctors, a dentist, chiropodist, optician and speech and language therapists. Care records included a section to record when people were seen or attended visits with healthcare professionals so any advice given was recorded for staff to follow. A relative told us, "The nutritionist comes and the doctor comes. I think they do keep me up to date."

Good

# Is the service caring?

## Our findings

People and their relatives told us staff had a caring approach. One relative told us, "They are always kind and cheerful." Another said, "I've never seen anything but good caring."

At our last inspection we found care was more task focused, and less centred on the needs of the individual. At this visit we found improvements had been made. People were supported by kind and caring staff and staff we spoke with demonstrated a commitment to want to care and enhance people's lives. Staff spoke with people in a polite way and listened to them. One relative told us, "They are almost like friends. They do listen I feel." Another said, "They know all her moods; they sit and talk to her." One person was brought into the lounge in a wheelchair. The window was open so staff brought a blanket and carefully placed it over them.

Staff told us they regularly worked with the same people so they knew them well and understood how they wanted to be cared for. Staff had good knowledge of people's individual behaviours, especially those that became challenging and staff knew what the causes were and how to keep people safe and well cared for. Staff managed people's emotions, moods and anxieties with ease and demonstrated a calm and caring approach which worked well with people. They told us they had learnt some useful techniques to support individual people when the cause of their agitation was not clear. Staff recognised when their approach was not working and were mindful of how they continued to maintain their support. One staff member explained, "We always try, we can't force and we let them do what they want. We can always come back, or get someone else. There is no rush."

Staff referred to people by their preferred name, and maintained eye-to-eye contact when speaking with them. People responded positively to staff because they used appropriate language and tone of voice. We saw people's facial expressions relaxed when staff referred to them by name or when they talked with them and chatted about their previous occupations or family.

We observed one person was feeling anxious and a little confused. They kept referring to a topic and then apologising for talking about it. A member of staff sat by the side of them, with their hand on their arm and said, "You can talk about it as much as you like, I've got all day. Is there anything we can do to help? Would you like me to sit with you? Is that nice just having someone to sit and chat to?" The member of staff stayed with the person until they were more settled.

Staff were patient and kind with people who were not able to express themselves clearly. They took time when speaking with people and changed their approach when people were struggling to understand them. One relative explained, "[Person] can't speak but they do their best." Another said, "They understand what [person] says. It might not make much sense; they are very patient with her."

We saw examples of staff taking time with people when delivering care so they did not feel rushed such as when providing them with assistance to move from one area of the home to another.

Relatives told us their relations were treated with respect appropriate to their lives and experience. People were supported to maintain their dignity and staff respected their privacy. People's hair, clothes and nails were clean and we observed staff gently wiping people's mouths after their meals and straightening their clothes to maintain their dignity. When staff visited people in their rooms, they knocked first and called out to let them know who was at the door, before entering. One relative told us, "They always knock before they come in." Another said, "I have been in the room when they wash her, they always close the door."

When people were in communal areas, staff continued to monitor people's personal care respectfully and in a dignified way. During our inspection we saw a person displayed behaviours which could cause the person's self-respect to be compromised. Staff were quick to intervene, reassured the person and supported them in a respectful and dignified manner.

People's care plans included a section entitled 'My day, my life, my story' which included details about people's family tree, work life and important relationships. This information supported staff to better understand each individual and promote meaningful relationships between people and staff. One staff member told us they used this information to talk with people which usually relaxed them so they were able to offer them the help they needed. Staff said this was particularly important when supporting those who needed help with personal care, but who sometimes became anxious.

People were supported to maintain relationships and friendships with those people who were important to them. We were told there were no restrictions on visiting times and saw visitors arriving at the home during the day.

Information about people was kept securely in locked cabinets. This meant their confidentiality was respected.

Good

# Is the service responsive?

## Our findings

People felt staff responded to their needs. One person told us, "They have a marvellous approach to things." A relative said, "I find it very good, no complaints at all. They are well looked after." Another said, "If I ask for help, it is forthcoming straightaway." One relative particularly told us staff responded quickly if they raised a concern, "The other day [person] was in the lounge in her slippers. I didn't like that from a safety aspect. I asked staff to change them, they did straightaway."

People's care needs were assessed and their relatives had been involved in the initial assessments to plan care. This ensured people's needs could be responded to before they moved to the home. One relative told us, "The registered manager came over to see [person] and talked about what their needs were and whether they could meet those needs. The person who used to care for [person] was able to come in on their first day and they went through his routine and everything with them. They have been really good and if I need to know anything, I just ask them and they will help with whatever it is."

Care plans we looked at were detailed and included information about people's individual needs. Care plans were up to date and were reviewed regularly in response to changing needs.

We received mixed responses from people and their relatives about their level of involvement in care plan reviews. One relative told us they had not had a review of their family member's care plan, but another said, "They gave me a review plan a month ago which I updated and signed." The registered manager told us they had introduced a new 'resident of the day' system where each day one person's care plan was reviewed to ensure it continued to meet their physical, emotional and social needs. Relatives were invited to the review. One relative confirmed, "There is a new system, a monthly review on the 27th of the month. If I want to be part of it I can be."

Staff were knowledgeable about the people they supported and knew in detail the individual ways people wanted to be supported, and on occasions when it was best to 'give people space'. Staff said they knew about people because, "We read care plans and we have a hand over (of information) between shifts." Another staff member told us about one male person who could become agitated with other men. They explained, "We try to use a female carer when giving him personal care." This demonstrated that staff had identified a different gender and approach was appropriate to respond to this person's needs. One relative felt confident staff had a good understanding of their family member and told us, "[Person] prefers tea without sugar, staff know that. In the serving room they have a note of what everybody likes."

During our visit we saw staff were responsive to people's needs. When people made requests for food, it was promptly provided. When staff saw people walking who were at risk of falls, they offered support or assistance to make sure they did not fall.

A senior staff member said they provided a handover to staff as each shift changed and focussed on those people whose conditions had changed, people who needed monitoring or those experiencing anxieties. This meant essential information was given to staff so they could respond to people's needs in a consistent way.

A member of care staff confirmed, "When you are doing personal care you pick up on any changes. It would be written in the care plan and communication book. If there are any changes we share it in handover."

At our last inspection visit we identified some improvements were needed to ensure the social needs of everyone in the home, including those cared for in bed, were met. At this inspection we were told the number of activities co-ordinators had been increased to four and a further two had been recruited to bring the number to six. This meant more activities could be provided to meet the varying needs of people. The registered manager had also sought the advice of a specialist nurse in dementia care to ensure activities were appropriate and meaningful.

One member of the activities team was confident improvements had been made and said, "I love my job… we plan for the week but always judge it on people's moods. We do group sessions and support those on a one to one, especially those in their rooms." We were told of a new gardening club where people were able to go into the garden and plant flowers and vegetables. We were told this was very successful and encouraged people to go outside when the weather was pleasant. Another innovation was the memory café where people were able to explore boxes of memorabilia and discuss and share their memories. During the afternoon of our visit we saw people being encouraged to touch, taste and smell different exotic fruits which provided them with a sensory experience and also encouraged conversations between them.

Staff were now able to spend more time supporting people to pursue their individual interests and hobbies. We were told of one person who supported a particular football team and staff had taken them to the local pub to watch the matches.

Care and activities staff said they enjoyed and spent time chatting with people about day to day things, such as the garden, weather and national news. One activities co-ordinator explained how they were now able to spend more time with people in their bedrooms. "We are going in and sitting with the residents, chatting to them and reading with them. It is still a work in progress because they need a visit from us at least once a day, even it if it just watching TV with them and chatting about it. That is a mission we are still on, but we are getting there."

During our visit we saw some people engaged in 'doll therapy'. One activity co-ordinator said the doll therapy was recently introduced, and whilst it was not for everyone, some people had really benefited from it. Staff recognised that soft toys brought other people comfort and ensured these were transported with them around the home. One person had a soft toy on their lap at breakfast time. Staff told us they liked to have this with them even when in bed as it gave them reassurance and comfort.

Some action had been taken to change the environment to support people who lived with dementia such as coloured doors and photo boxes next to doors so people could easily locate and identify their bedrooms. Call bells were discrete so they didn't alarm people and reactive lighting in corridors responded to movement if people were up at night. Further plans were in place to introduce objects to engage and stimulate people as they moved around communal areas.

There was a system and procedure in place to record and respond to any concerns or complaints about the service. Information about how to make a complaint was available in the reception area of the home. However, we received mixed responses when we asked people whether they knew how to make a complaint. Some said they were not aware of the procedure, but felt that was because they had not had to make a complaint.

Staff told us they would support people if they needed to share any concerns. One staff member explained,

"Care staff pass the message to nurses if there is no management staff here. If there is something we can do at that time, we will try and sort it out and then inform the management."

The registered manager kept records of any complaints including the nature of the complaint, actions taken and the outcome. Records showed that where concerns were upheld, action had been taken to ensure improvements to systems implemented.

Good

# Is the service well-led?

## Our findings

At our last inspection visit we found a high turnover of managers had led to inconsistency of leadership which had impacted on the quality of care people received. The provider's audit systems had not always identified areas where improvements were required. At this inspection we found improvements had been. The manager had been in post for twelve months and had completed their registration with us.

People and their relatives generally felt the home was well-led. Comments included: "I know it sounds stupid but I am quite happy with everything", "Nothing to improve, I'm quite happy with the care. I would give it 9/10." and, "I think the home is well managed."

Since our last inspection visit, there had been some additions to the management team and there was a clear strategy to formalise leadership within the home. The registered manager was now supported by two clinical services managers (CSM). One had clinical knowledge and the other had a strong background in dementia care. Each CSM was allocated a floor of the home and responsible for the quality of care provided on that floor. The registered manager explained, "They are my eyes and ears that I hadn't got before. They work together to make sure we are doing things uniformly but bringing an individual feel to each floor. This collaborative approach is giving us the momentum to improve that we didn't have before, but recognises the uniqueness of each unit. They pick up much faster on any poor practice and say 'let's performance manage this'. Again, that has helped the momentum of change."

Both CSMs demonstrated a good understanding of their role and their key responsibility to drive improvement. One CSM told us, "I have done 360 degree feedback with staff. I want to work on the floors and wanted to know what staff thought of me. I want to get to know people better as it would give me a better insight to their needs." The other CSM told us there were still areas for improvements to be made. For example, in the records staff completed to monitor when people exhibited challenging behaviour. They told us, "Staff are good at managing it but not always recording it." They planned to provide extra support and training for staff in this area.

The registered manager had also appointed team leaders and senior care staff to provide further leadership on shift and improve communication. Senior staff undertook a three day course in leadership so they had the skills to fulfil the responsibilities of their role.

During our inspection visit we found staff felt more competent in their roles because they had confidence in the management team to provide leadership and support. Staff respected and appreciated the registered manager's leadership and felt the registered manager had made a positive difference since our last visit. They told us the registered manager was open, honest and approachable and listened to their views. Staff felt assured that actions promised would be implemented. Comments included: "Everything they said they were going to do they have done" and, "She (registered manager) is trying to help us more. If there are any problems she is trying to fix them for us. I think she is doing a good job"

One area where relatives raised a number of concerns was about the high turnover of staff and the lack of

consistency and how this impacted on the care people received. The registered manager accepted there had been a period when there was a high number of staff vacancies, but after a successful recruitment drive, most vacancies had now been filled. Staff confirmed they were beginning to work well together as a team. They told us communication and teamwork had improved in the last six months. One staff member told us, "Now we are working as a better unit. Before it was agency everywhere and everybody was arguing but now it has calmed down." Another said, "The credit goes to the current manager. She has a huge sense of human resource management. She listens and tries to meet each person at his or her point of need and takes time to see how care workers are. When you have a steady team it improves the level of care of the residents. She has recruited massively and people are doing their job to the best of their ability."

Staff told us they had regular opportunities to get together and discuss the service, any issues or good practice. They said they felt confident to report poor practice and that action would be taken. One staff member explained, "When I first came there was a lack of personal hygiene and basic care. I reported that and I feel that this had got loads better."

The introduction of the clinical service manager roles in the home to provide support and leadership had allowed the registered manager more time for their managerial duties. The registered manager explained, "I just feel I can start to do my job, before I was trying to be a unit manager and a deputy manager as well. I can now analyse and assess and be much more proactive rather than reactive. There is a lot more planning going on now." This was demonstrated by the accident and incident records. The registered manager had analysed these for any trends or patterns, such as the time of day they occurred or whether any particular individual was more prone to falls. They had identified that more falls were occurring between 4.00pm and 6.00pm when people were beginning to feel tired. Changes were being implemented to the timing of meals and shifts so key staff, such as the hostesses and activities staff were available during this critical period.

Another area where the registered manager had identified improvements needed to be made was in clinical oversight within the home. A white board in their office contained information about areas of risk, such as people with skin breakdown or who were at risk of falls so they could see where the highest risks were. There was also had a daily 'walk around' and meeting where the heads of department came together to discuss any clinical issues so they could ensure they were being effectively managed.

There were processes to check the quality of care within the home. The registered manager and CSMs were responsible for checking the work care and nursing staff had undertaken to make sure people who lived at the home were safe. This included medicines checks and care plan checks. Where areas for improvement were identified, these were followed up with staff.

The provider carried out a number of audits and quality checks. The provider's regional director visited the home on a monthly basis to check if the home was complying with their expectations and whether identified areas of improvement had been made. They also spoke with a sample of people and staff at the service and listened to their views. The checks were reported under the same headings of 'safe, effective, caring, responsive and well-led' as a CQC inspection. The registered manager showed us a copy of an improvement plan they had put in place to address the issues identified at the last provider visit. The improvement plan would help ensure care was being delivered in accordance with the fundamental standards of care.

People and relatives were invited to share their experiences of the service provided at Canning Court through an annual quality survey and regular meetings. We saw the home had a 'Customer Feedback' board where the manager responded to issues raised during the meetings. One recurring issue was a concern from relatives that mealtimes needed to be more organised as sometimes people's food was not always hot when it arrived. The registered manager had listened to these concerns and planned to change the main

meal of the day from the evening to lunch time when more staff were available to support people.

The registered manager also wanted to support relatives in their understanding of dementia and dementia care. They had offered the 'virtual dementia' training to relatives and had also invited relatives to attend monthly 'dementia awareness sessions'.

The provider had, when appropriate, submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes involving the service within a required timescale. This means that we are able to monitor any trends or concerns. The ratings from our previous inspection visit were prominently displayed in the home.