Bupa Care Homes (ANS) Limited

Canning Court Care Home

Inspection report

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20 December 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 19 and 20 December 2016. The first day of our inspection visit was unannounced. We told the manager we would be returning the following day.

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. Most people who lived at Canning Court had limited mobility and all but one of the people had a diagnosis of dementia. At the time of our inspection there were 62 people living at Canning Court, which increased to 63 when another person was admitted on the second day of our inspection visit.

Canning Court is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the time of this inspection, this service did not have a registered manager in post. A new manager had been appointed and had been in post for seven months. The new manager was in the process of completing their application for registration with the CQC when we visited.

Whilst people generally felt safe living at Canning Court, some people expressed concern because other people would frequently walk into their bedrooms uninvited. We were told staffing levels were set by the provider based on an assessment of the level of care each person required. However, the assessment tool did not take into account the spacious layout of the home. The deployment and management of staff meant there were times when there were not enough 'eyes and ears' to monitor people safely as they walked around the home and interacted with each other.

Staff and the manager knew how to report allegations of abuse and previous safeguarding notifications showed the provider had acted as required. However, we identified occasions when people had been pushed over or hit by others which had not been reported to the local authority or ourselves as potential safeguarding incidents.

Medicines were managed safely and people received their prescribed medicines. Staff were responsive to fluctuations in people's health needs and people had good access to health care professionals when required.

Staff received an induction and on-going training to carry out their role effectively. The manager had planned further dementia care training to provide staff with further skills and knowledge in this area. Staff told us they had opportunities to talk about their roles within the home at one to one meetings with senior members of staff.

Staff understood the principles of the Mental Capacity Act 2005 and assumed people had capacity to make everyday decisions. Staff sought people's consent before supporting them. Mental capacity assessments had been completed where it was believed that a person did not have the capacity to consent to a specific decision.

The provider had identified people whose care plans contained some restrictions to their liberty and had submitted the appropriate applications to the authorising authority in accordance with the legislation.

People were treated with kindness and thoughtfulness by staff who knew them well. Staff understood people's behaviours and attitudes and supported people as individuals which helped manage their anxieties, emotions and behaviours.

Staff employed to organise activities were able to provide opportunities for engagement and stimulation for people, but other staff had little time to respond to people's social needs as they were busy completing other care tasks. People cared for in bed had little to do to keep them occupied or to stimulate them.

Many of the people who lived at Canning Court, whilst having a diagnosis of dementia, also had complex physical and medical care needs. Records demonstrated the nursing care provided to people was responsive to their needs.

There had been a number of managerial changes within the home which had led to inconsistency in leadership and this had impacted on the quality of care people received. The provider's audit process had identified their management of the home during this period of instability had not been effective in maintaining the quality of care people received. The new manager had been in post for seven months and improvements in service provision had already been identified. The new manager was aware that staff needed a consistent leadership approach and was committed to ensuring people received high quality, personalised care from equally committed staff. Staff described the new manager as 'supportive', 'approachable', 'visible' and told us morale had improved within the home.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The deployment and management of staff meant there were times when there were not enough 'eyes and ears' to monitor people as they mobilised around the home and interacted with each other. Some incidents and accidents had not been recognised as potential safeguarding issues and referred to us and the local authority as required. Medicines were managed safely and people received their prescribed medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider trained staff to equip them with the right skills and knowledge to support people in their care. The manager and staff worked within the principles of the Mental Capacity Act 2005 and sought consent from people before delivering care. Staff felt changes in how information was shared between shifts was not effective. People's healthcare needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were treated with kindness and thoughtfulness by staff who knew them well. Staff understood the signs and behaviours individual people displayed that indicated when they were anxious or becoming agitated. However, staff were not always able to give people their undivided attention at the time they needed it. People were encouraged to maintain relationships with those who were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently response.

The nursing care provided to people was responsive to their needs. People's changing needs were kept under review and monitored in their care plans. Activities staff were able to provide people with opportunities for engagement and stimulation, but

other staff had limited time for social interaction and conversation with people. Some people did not feel able to raise their concerns within the home, because they did not feel previous concerns had always been responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A series of management changes within the home had led to inconsistency in leadership which had impacted on the quality of care provided. The provider's own audit system identified that improvements were required to ensure people received high quality person-centred care. A new manager was in post and committed to building a strong leadership team to drive improvements in the home. Staff spoke highly of the new manager and told us the atmosphere in the home was good and staff morale had improved.

Canning Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 19 and 20 December 2016 and was unannounced. The inspection was undertaken by three inspectors, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of service. The specialist advisor who supported us had experience and knowledge in dementia and nursing care.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the previous registered manager and the current manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority. The commissioners did not share any concerns with us.

Before the inspection visit, the provider completed a Provider Information Return (PIR). This 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. The PIR had been completed by the manager and gave detailed information about the service.

We spoke with eleven people and ten relatives about what it was like to live at the home. We spoke with eight care staff, seven nurses and five non-care staff about what it was like to work at the home. We spoke with the manager, the recently appointed clinical services manager and the area manager about their management of the service. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

We reviewed six people's care plans and daily records to see how care and treatment was planned and delivered and looked at 41 medicine administration records. We checked whether staff were recruited safely,

and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Whilst people generally felt safe living at Canning Court, some people expressed concern because other people would frequently walk into their bedrooms uninvited. One person told us they liked their bedroom door to be open so they did not feel socially isolated. However, the person now chose to sit in their room with the door closed because other people came into their room and this caused them distress and anxiety. A relative explained, "The big problem is that the other residents come in and out of her room." This was confirmed by another relative who told us, "[Person] is paranoid about new people coming through the door. They insist we keep it closed."

People who lived at Canning Court benefited from an environment that was light and spacious and provided them with large areas to walk. There were four communal lounges on each floor. However, the layout of the building presented challenges as corridors and rooms were not always in view, and people who spent time in these rooms, were not always checked and observed. One relative felt the issue with people going into other people's bedrooms was because staff were not always available to observe people as they explored their surroundings. They told us, "The problem with this home is its shape – the carers are at the top of the horseshoe and the two branches are difficult to monitor."

Nursing and care staff told us that during the day there were generally enough staff to meet people's physical needs and keep them safe. Staff on the first floor told us the home had recently returned to full occupancy, so staffing levels had increased to seven care staff, with two nurses supporting. One staff member said that with those staff levels, "No-one goes without." Staff said seven care staff enabled them to support people in line with their wishes, however, when unexpected absence was not covered on the shift, staff said it became more difficult to cope. During the first day of our inspection visit, one staff member had not come in to work and their shift had not been covered. A staff member said, "It's difficult, really busy, but we all muck in. It happens quite a bit like today, we only have six (care staff)." Nursing staff shared similar concerns saying, "When we are short, we can only provide task based care."

Staff also told us that a number of care staff had recently left the service. They told us that whilst new staff had been recruited, the high turnover of staff, "Affects people's experiences, new staff are not up to speed in knowing people's preferred routines and preferences." A relative confirmed, "The staff continually change. They are all doing their best though."

Prior to our inspection visit we received some concerns that staffing levels at night were not able to meet some people's needs. We therefore visited during the evening and observed and spoke with night staff. On the ground floor unit staff expressed concerns about there only being one nurse and three care staff between 8.00pm and 11.00pm to meet people's needs. They told us staffing numbers were sufficient if everyone was calm and relaxed. However, three staff members was not enough if people became anxious or agitated. This was because people were living as a group and some people's negative behaviours impacted on others and caused their behaviours to escalate. Staff told us the layout of the home meant it was difficult for staff to see where people were and they did not always have the time to monitor people's interactions which increased risks to people in the home. One staff member told us they found it difficult to manage if

people became anxious or agitated and explained, "I think we need one more staff on this floor because some people are walking around all the time." Another staff member said they were "struggling at night" because people were walking up and down and sometimes having negative interactions with each other. Staff explained that 20 of the 32 people on the ground floor required the support of two staff members with personal care. This meant if staff were supporting one person with personal care there was only one member of care staff left on the floor to support the other 31 people. One staff member told us, "If something happens and I am on the floor by myself I can't handle it. You need two staff members each side of the unit to keep eyes on the floor." Care staff told us the nurse was available to support them, but this was challenging if the nurse had to interrupt their medicine round to provide support. One member of nursing staff explained this impacted on people because sometimes they had fallen asleep because the medicine round had been delayed. They told us, "It can take to 10.30pm or 11.00pm to complete the medication round. If they are asleep it is not fair to wake them." One staff member told us, "We have brought it up with the manager but that is the staffing levels we get from head office."

The manager explained the provider used a tool which assessed each person's nursing and care needs. The staffing levels described were those that had been set by the provider on an assessment of the level of care each person required. However, we were concerned this did not accurately reflect the number of staff required to keep people safe because the assessment tool did not take into account the layout of the home and the fact some people required close observation and supervision. It also did not take into account the demands of people with a diagnosis of dementia living together as a group. Whilst the manager felt confident that the levels of staffing were sufficient to keep people safe, it was clear the deployment and management of staff meant there were times when there were not enough 'eyes and ears' to monitor people as they mobilised around the home and interacted with each other.

During our inspection visit we saw a number of occasions when people walked into other people's rooms unseen by staff and uninvited, which caused some people who were in bed, distress. On the first day of our inspection visit we heard a call bell alarm ringing for a few minutes. We went to the room identified on the call monitoring system and found one person who was at risk of falling was standing on a mat which had triggered the call alarm. Staff who were close by did not call in to check this person was safe. After a few minutes, we saw this person, who appeared anxious, leave their room and go into another person's room. We called the nurse to escort the person out. Some care staff said this happened frequently but they did not have time to check people because they were busy helping others, such as with personal care or assisting people at mealtimes. Accident and incident reports showed there had been three episodes of concern in November 2016 when people had entered other people's rooms unobserved.

We also saw occasions when people were put at risk of harm because there were no staff around to monitor them. At around 8.30pm on the first day of our visit we saw the tea trolley had been left in the corridor on the ground floor with a full pot of hot tea on the top. The pot was metal and very hot to the touch. There were no staff in the corridor. A person was walking along the corridor and walked towards the trolley. They could easily have poured the hot drink over themselves or others and put them at risk of injury.

On the second day of our visit one person walked into the library where our inspectors were sitting. The person was very distressed and unsteady on their feet. We had to intervene and support the person to prevent them from falling. There were no staff around to monitor this person. We looked at records of falls in the home. In November 2016 there had been 27 falls in the home. Only three of those falls had been witnessed, even though 14 of them occurred in communal areas.

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

We asked staff how people at the home remained safe and protected from instances of abuse. Staff completed training in safeguarding people and understood what abuse was and how to keep people safe. One staff member told us, "Safeguarding can be anything, financial abuse, neglect, physical abuse, sexual abuse and anyone can be an abuser. If I saw something I would report it." Another staff member supported this by saying, "We have a policy called 'speak up', we could report concerns to the managers." Staff we spoke with said they felt confident to raise concerns where any allegations of abuse were seen or heard. When we asked the manager what type of incidents they would report as safeguarding matters, they responded, "Challenging behaviours when there is interaction between two residents, harm to residents in any shape or form that is unexplainable." The manager said any allegations of abuse would be reported immediately and referred to the provider, local authority and to CQC.

However, during our visit we looked at accident and incident reports and identified occasions when people had been pushed over or hit by others which had not been reported to the local authority or ourselves as potential safeguarding incidents. For example, on 2 November 2016 one person had hit another person. On the 4 November 2016 a male person was found in a female person's bedroom in a state of undress and wearing some of their clothing. On the 9 November 2016 one person had gone into another person's room, grabbed their arm and caused a skin tear. On 19 November 2016 one person had been found on the floor of their bedroom with another person standing over them. They said the other person had hit them over the head. None of these incidents had been reported as safeguarding issues. It is important such incidents are reported to keep people and others safe when they demonstrate behaviours that can cause distress or injury. We also identified a safeguarding incident that had been referred to the local authority in November 2016 that had not been notified to us which is their legal responsibility.

We found this was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

The provider's recruitment process was thorough which meant risks to people's safety from unsuitable staff were minimised. The responsible staff member for recruitment checks obtained references from previous employers, checked people's identity and that professional registrations were up to date. Part of the provider's recruitment process checked qualified staff's qualifications and conduct, to ensure they were skilled, competent and effective in their roles. Checks were made to see whether the Disclosure and Barring Service (DBS) had any information about staff. The DBS is a national agency that keeps records of criminal convictions. All staff had to wait for these checks and references to come through before they started working in the home.

The risks associated with each person's care and support had been assessed, recorded and plans developed to manage these. Risk assessments covered areas such as moving and handling people, nutrition and falls. They were updated monthly or more frequently if required to ensure any changes in risks were identified and minimised.

We looked at the risk assessment for one person who was at very high risk of falls. Records showed the person was medically reviewed and the risk assessment updated after each fall. The person had been referred to physiotherapy and podiatry for support to minimise the risks to their health.

Another person was at risk of skin breakdown. A staff member explained how they managed the risks to this person stating, "If they are bed bound we make sure we turn them and clean them and put cream on them. If we see any red skin we have to tell the nurse and do a body map so it is checked." Daily records showed the person was receiving the care outlined in their care plan to prevent any deterioration in the condition of their skin.

Staff told us equipment to keep people safe was readily available and well maintained. One staff member told us, "There are no issues with equipment here. Maintenance is not a problem. If something is broken we put it out of action and record it for maintenance."

We looked at how medicines were managed in the home. Medicine storage was secure with access only by authorised members of staff. People's medicines were supplied and labelled individually and kept secured in locked medicine trolleys. Medicines were stored within the recommended temperature ranges for safe medicine storage. Arrangements were in place to ensure that liquid medicines with a short expiry were dated when they were opened to ensure they remained effective.

People's medicines were available to give to treat their diagnosed health conditions. Medicine administration records (MARs) were completed to document if people had been given their prescribed medicines and any reasons why a medicine had been omitted, for example a refusal. We observed a nurse administering medicines from the medicine trolley. This was undertaken following safe practice to ensure the correct medicine was administered and recorded on the person's MAR chart.

However, some people were prescribed medicines that should be given 30 to 60 minutes before food and other medication. Although this was clearly stated on the MAR chart, there were no arrangements in place to ensure these specific administration instructions were followed. One person was prescribed a medicine to slow and strengthen the heart rate and should not be given if the pulse rate is below 60 beats per minute. Records did not demonstrate that the person's pulse was consistently being taken to ensure it was safe to give the medicine.

Supporting information for staff to safely administer medicines was available and accessible. There was clear documentation for the site of medicine patch applications on a person's body. This was particularly important for pain relief medicines so nurses were aware where a medicine patch was located. When people were prescribed a medicine to be given 'when required' we found person centred information was available to enable nursing staff to make a decision as to when to safely give the medicine. A number of people were prescribed 'when required' medicines for pain relief. People with dementia are at high risk of being undertreated due to their inability to express or describe pain. The provider used the 'Abbey pain scale' which is a recognised tool to identify pain for people with verbal language barriers.

Some people received their medicines 'covertly', that is disguised in food or drinks. Records showed the GP and people's relatives had been consulted to ensure medicines were being given covertly in the person's best interests. There was also evidence that the pharmacist had been consulted. This was good practice as some medicines are not suitable for crushing or being given with certain food types.

A member of nursing staff told us they had received training and regular updates in the safe management and administration of medicines. They told us their competency to give medicines safely was regularly assessed. They understood what action to take in the event of an administration error to ensure the safety of the person in the first instance, and then how this was recorded as a medical incident.

The provider had procedures and policies in place to ensure the safety of the environment and minimise the impact of unexpected events happening at the home. This was to ensure people were kept safe and received continuity of care. There were a series of emergency folders available in the reception area which contained contact numbers of suppliers to be contacted in the event of an interruption to services to the home. This included electrical power failure, loss of heating or a gas leakage. There was also up to date information to instruct staff and the emergency services about what level of support each person would need if the building needed to be evacuated.

Requires Improvement

Is the service effective?

Our findings

Relatives felt the care provided at Canning Court was effective in meeting people's medical needs. One person told us, "The nurses are good at medical attention so we don't need the GP."

Staff told us they had the right skills, training and experience to carry out their role effectively. Newly recruited staff received a comprehensive five day induction that was designed to prepare them for working within the home. Newly recruited staff told us the induction also involved working alongside experienced staff members before they provided care on their own. One recently employed staff member said, "I had a week's training and after that, I shadowed for a few days which was useful, the senior staff taught me (about people's needs)." They said they used this 'shadowing opportunity', together with reading the care plans so they had the necessary information to support people. Another told us the induction, "Gave me more than enough skills and I learnt lots of things."

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.

Each staff member had an individualised training plan that was specific to their role. Staff confirmed the training they received helped them to do their job. One staff member told us, "I did moving and handling, fire safety, communication, infection control and food hygiene." One member of care staff told us they had recently completed dementia awareness training and explained how they implemented this into their practice. They told us, "From the dementia training I learnt you need to communicate very gently and politely and use your body language." However, the manager had identified that staff would benefit from further training in this area. They told us, "The most important thing is training in dementia care. They (staff) haven't done it to the level I want them to have it." The manager had arranged for two care staff to undergo training in 'delivering excellence in dementia care' which they in turn were going to cascade to all staff in January 2017. The manager explained, "We are going to do small workshops of a maximum of six staff. By the end of April 2017 every member of staff will have completed the workbook on dementia awareness and the 'excellence modules', all staff whatever their role."

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. The manager explained they planned to use supervision for nursing staff as an opportunity for reflective practice and to discuss issues that could have been managed better to improve the outcomes for people. They told us, "It is a way of enhancing practice without it being seen as a negative."

Staff had a handover of information between shifts so they understood people's needs on a day to day basis. However, staff felt the handover was not as effective as it used to be because it was given verbally with only limited written notes. Staff told us that previously the handover had been recorded in more detail so they were able to refer to it to refresh their knowledge throughout the shift. One staff member told us,

"Handover is twice a day. The nurses and senior carers do the handover. It's changed now, it's not a proper handover. I can't remember about the people." Another member of staff said, "It is just not saying a lot really." The manager told us they were aware of staff concerns and were in the process of developing a new handover sheet for use within the home.

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

Staff understood the principles of the Act and assumed people had capacity to make everyday decisions. 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 the person's facial expression and body language, to understand whether they consented to support. Staff recognised seeking consent from everybody was important and we saw examples across both days of our inspection visit, where staff offered people choices, such as, where to sit, what to do, what to eat and drink. One staff member said seeking consent was an important part of their role because, "It's their right, you can't make every choice for people." Another said, "We might offer them to use the toilet and they might refuse, we offer again later and encourage them. They have to consent to the care."

Mental capacity assessments had been completed where it was believed that a person did not have the capacity to consent to a specific decision. However, staff understood that some people's ability to consent fluctuated depending on their health and wellbeing. One member of nursing staff explained, "We assess capacity all the time, many of our residents have fluctuating capacity." When people were unable to consent, staff told us they acted in people's best interests. One staff member explained, "Some days [person] can tell you what they want, you have to judge based on their behaviour and work in their best interests."

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. Senior staff understood their responsibilities under the legislation. They had identified people whose care plans contained some restrictions to their liberty and had submitted the appropriate applications to the authorising authority. Some people had conditions attached to their authorisation. The clinical lead was preparing care plans at the time of our inspection visit to ensure the conditions were being met.

People who lived in the home had their main meal in the evening and a lighter lunch. People were offered a choice of main meals and desserts. A menu with the day's choices for breakfast, lunch and the evening meal was displayed outside the dining room. However, people were not shown a plated meal to visually support them in making choices which we were told was something the manager wanted to introduce.

Guidelines for good dementia care recommend that food should be presented in a way that looks good to encourage people to eat and crockery should be used in colour contrast to the food to support recognition. Aids should be used to promote independence such as adapted cutlery and plate guards. During the lunch time meal we observed there was no use of any of this type of equipment. A member of staff confirmed there was no specialist equipment currently available, but told us the manager intended to order some.

Most people needed some degree of support with eating. We observed one person being assisted with their

meal. The member of staff assisted the person into an appropriate position to eat their meal and sat next to them. They described the meal to the person and checked that the temperature was acceptable to them and they liked what they were being given. The person was supported to eat at a pace that was comfortable to them. However, we saw another person being assisted to eat. Whilst the member of care staff supported the person gently and slowly, they had to leave the person several times to meet the needs of the other three people in the room. One person was reluctant to eat the main choice so a member of staff brought a pudding and a yoghurt which were both eaten. This person indicated that they had eaten enough by raising their hand and this was respected by the staff member.

People were assessed to determine whether they were at risk of malnutrition and where risks were identified, care plans were put in place to assist staff in meeting their needs. We looked at the records of two people who had lost weight. They had been referred to a dietician who had prescribed thickeners and supplements. Their care plans reflected the advice given by the dietician and their food and fluid intake was monitored and they were regularly weighed. However, we identified another person who had lost a significant amount of weight. The weight loss had been discussed at a management meeting in November 2016 when it was decided to refer the person to a dietician. This decision had not been passed on to nursing staff who were unaware of it. The referral had not been made at the time of our inspection visit.

We were told that information was shared with the kitchen staff to ensure people's individual needs were met. This information was kept in a folder in the chef's office and detailed each person's dietary requirements. On the second day of our inspection visit the chef was not working and staff working in the kitchen were not aware of the folder.

Care records showed that staff were responsive to fluctuations in people's health needs and referred them to health and social care professionals when a need was identified. People were also supported to attend regular health checks to maintain their health. These included the dietician, dentist, the speech and language team (SALT) and physiotherapy services. A twice weekly GP surgery meant people received consistent support for their medical needs.

Requires Improvement

Is the service caring?

Our findings

People and relatives were positive in their comments about the staff. They told us, "The carers are saintly" and, "They are good carers. No problems whatsoever." One relative told us, "I think the care is okay here, there is nothing that could be done better. We looked at many homes and we thought there was a good attitude of staff here." A staff member told us, "Staff are caring, we speak to people quietly and patiently."

During our inspection visit we saw people were supported by caring staff. People were treated with kindness and thoughtfulness by staff who knew them well. Staff understood people's behaviours and attitudes and supported people as individuals which helped manage their anxieties, emotions and behaviours. Staff communicated with people effectively and used different ways of enhancing their communication by using touch, ensuring they were at eye level with those people who were seated, and altering the tone of their voice appropriately. We saw people's facial expressions relaxed when staff touched their shoulders or arms while talking with them.

Staff were able to explain the signs and behaviours individual people displayed that indicated when they were anxious or becoming agitated. Staff we spoke with understood how to reassure people to decrease their agitation. For example, staff were clear that if they told one person they needed help with personal care, it would cause them to become agitated and display behaviours that could challenge them and others. Staff told us they used a 'low arousal' approach. If the person refused assistance with personal care, they would leave them and try again later; they told us this usually worked. A staff member explained, "Each and every day people vary in how they are, they can be quiet or agitated, we accept what they are. We make sure we are patient, polite and wait for them, we give them time."

Staff understood the importance of person centred care, but felt frustrated at times that they did not always give people their full attention at the time they needed it. One staff member told us, "I love just sitting and having a cup of tea or chat, [person] loves this. We can do some of it, but not as much as we would like." Our observations during our inspection visit confirmed this. We saw staff were caring in their approach, but the main interaction with people was focussed on when they offered support or completed a care task. For example, we saw one person calling out in distress. We asked the person if they were okay and they responded, "Don't leave me." We found a member of care staff to reassure the person, however, the care staff member could only stay with the person for a couple of minutes as they were busy with other tasks. The person became distressed again when they were left.

Where staff did spend time with people, it was clear people enjoyed the engagement. We saw one example where a person became unsettled and staff responded calmly and sensitively and spent time reassuring them they were safe. The staff member stroked the person's hand, saying, "You're okay, what would you like, where do you want to go." The person moved from one chair to another, with staff supporting them with a 'comforting supportive arm'. When the person eventually found a chair they were comfortable in, the staff member got them a drink and told them, "Just relax."

Generally our observations confirmed that staff respected people's privacy and treated them with dignity.

Staff were observed and heard to be discreet when people needed assistance. Staff knocked on bedroom doors that were closed and identified themselves on entering the room. One staff member told us, "People here are respected by staff, staff are polite and treat people really well." This was confirmed by a relative who told us, "They are very good to [person] and talk to them nicely." However, we saw one person who was very distressed and unsteady on their feet. We had to intervene and support the person to prevent them from falling. Whilst supporting the person it was evident they had a strong odour on their body and breath and was in need of personal care assistance and oral care. Staff came to help the person and rather than talk with them and provide reassurance, their response was to put the person straight to bed. We asked why, and staff explained that the person would 'wander off again' and try and go into other people's rooms. Staff had not noticed the person required personal care even though they said they had provided it five minutes before. The person's dignity was not respected and staff behaviour was focussed more on the task of supporting people with serving the evening meal, than maintaining the person's dignity and respect.

The environment promoted people's wellbeing. Communal rooms were large, light and arranged to enable small groups of people to engage in separate activities at the same time. There were rooms where relatives could sit and take tea and coffee and a selection of biscuits were made available to people and visitors. People's bedrooms were decorated and furnished in line with people's choices. Some people and relatives who did not like the colours in their bedrooms had changed the colour to one of their preference.

People were encouraged to maintain relationships with those who were important to them. Throughout our inspection we saw relatives coming to the home to visit their family members. Visitors were able to choose whether to see people in private or sit with them in the communal areas. Families and friends could visit when they wished and stay as long as they liked. One relative told us they visited every day and that staff respected their relationship with their family member.

Requires Improvement

Is the service responsive?

Our findings

Many of the people who lived at Canning Court, whilst having a diagnosis of dementia, also had complex physical and medical care needs. People felt those needs were met with one relative saying, "They (staff) always seem to be very attentive." One person told us, "They (staff) look after me."

Care records demonstrated the nursing care provided to people was responsive to their needs. For example, one person with multiple medical conditions had a wound on their foot as a complication of their diabetes. Records showed this person was reviewed every week and nursing care was amended to meet their changing needs. There were good quality records of the wound which was dressed and managed in accordance with the wound management care plan. Staff were responsive to the person's pain levels and administered pain relief prior to wound care being provided.

People's changing needs were kept under review and monitored in their care plans. Records showed the views of people and their relatives were reflected in the reviews and evaluations, although this was not always done consistently. One relative told us, "I was once shown the care plan file 18 months ago – not since – it was specific to [person] and was about their needs then." Another relative told us they had been invited to a review "about a year ago".

When the new clinical lead commenced work at the home in October 2016, they completed an audit of care plans and identified that many required updating to ensure they accurately reflected people's needs. This was a 'work in progress' at the time of our inspection visit, but improvements had been noted in the recording of people's likes and dislikes and reflecting their individual preferences.

People's care plans included a section entitled "My day, my life, my portrait'. This was a 'pen portrait' of the person which included details about their identified risks and the level of care and intervention people needed. Staff knowledge supported people's pen portraits, although in one care plan there was conflicting information in the equipment the person needed to help them move safely and what staff told us. This meant there could be inconsistency in how this person was supported to mobilise.

We spoke with both members of staff responsible for organising activities within the home. They told us they used a weekly and monthly planner, but said this was only a guide and if people wanted to do something else, this was arranged. The activities staff said they worked around what people wanted and were able to be spontaneous. They said, "You have to make time and see what people want." During our inspection visit, 'arts and crafts' was planned, but we were told people did not want that so they did some music and movement instead. The activities staff told us they were responsive to people's hobbies and interests. They had recently learnt to knit themselves to set up a 'knit and natter' group. Pampering sessions supported people with aromatherapy, massage and a hairdresser regularly visited the home. The manager had recently introduced a 'Reika Master' who visited the home weekly. They were working with a small number of people to see what positive effects this alternative therapy could have upon their health and wellbeing. Activities staff said the men in the home wanted a darts board so they were planning on purchasing a darts board to put in the 'Canners Arms' pub room. Alcohol could be served to people and the use of the room

was being explored to make it a focal point for game type activities.

Both activities staff said they enjoyed and spent time chatting with people and knew people's likes and dislikes. One activities staff member said they had recently chatted with one person about relationships. They said, "We chatted about our first kiss, first boyfriend it was lovely. [Person] really loved talking about it. It brought back some happy memories and laughs and it led on to conversations about other things."

However, other staff told us they had little time to respond to people's social needs as they were busy completing other care tasks. This was confirmed by our own observations. Throughout our inspection visit staff supported people with physical care needs but there was limited time and opportunities taken by staff to engage people in social interaction and conversation. We heard one person ask a member of staff when the Second World War ended. The staff member answered the person but said to us, "I wanted to spend time talking with them about that, I just don't have time." Another staff member told us, "One to one time? We don't get that much time. After lunch until tea, sometimes we can chat with people."

We found people who were looked after in bed had little to do to keep them occupied or to stimulate them. The rooms lacked sensory equipment and radios and televisions were not switched on. It was not always clear whether these people were looked after in bed because of their care needs or by their own choice. Care records did not demonstrate that these people had support to reduce their social isolation.

The environment was not supportive of people living with dementia. There was a lack of directional signage in communal areas and the corridors were very similar in colour. Clear sign posting is important to promote orientation and independence. The manager had identified this was an area that required improvement. In the PIR they told us: 'We are just beginning an internal upgrade to make better use of the large lounge areas making them into areas of interest for residents to walk to or be taken to for interaction and social activity. We are linking these to things we do in our lives, for example, go to the shop, cafe, pub, health and wellbeing centre, cinema or library. The bedroom doors are to be painted in bold colours and will be individualised by the adding of door knockers and or signage flowers to aid recognition of the residents' own personal spaces. Better signage is to be utilised to support independence.'

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. One relative responded, "I am aware of the complaints procedure," but another said, "Not really apart from saying so here (on the unit)." One relative told us they were reluctant to raise concerns and some felt their concerns had not been responded to and chose to now raise their concerns directly with the provider.

We looked at the log of complaints for the last twelve months. We saw some complaints had been fully investigated and the outcomes communicated to the complainant in writing. There was also evidence of working with families to resolve issues and sharing of outcomes with staff members. However, we saw one complaint that had not been responded to within the provider's own identified timescales and the complainant had to chase a response. We also saw three complaints which did not appear to have been responded to. The manager assured us the complaints had been taken seriously and action taken to resolve them, but the file had not been updated.

Requires Improvement

Is the service well-led?

Our findings

Relatives were aware of who the managers and senior staff were in the home. One relative told us, "It is [name of manager], She has not been here very long." However, some relatives told us they felt reluctant to approach managers because of previous poor responses to their concerns. One relative told us, "We did have a residents meeting and I suggested a one-off meeting with a carer and a nurse – nothing has happened so far." Another relative told us they had put their concerns in writing because, "I never get a response if I speak to management directly."

Canning Court opened seven years ago and we were told that in that time there had been five managers. There had also been six interim managers to cover during the recruitment processes for suitable managers for the home. The new manager had been in post for seven months at the time of our inspection visit. Staff spoke about how the high turnover of managers had led to inconsistency in leadership which had impacted on the quality of care people received. One staff member explained, "It has been difficult because they (managers) all come in with their own ideas."

The provider carried out a number of audits and quality checks to ensure people received high quality care that was safe, effective and responsive to their individual needs. We looked at the most recent audits which were RAG rated. The RAG system is a method of rating based on red, amber and green colours as in a traffic light system, with green indicating a good performance, red a bad performance and amber that improvements were required. The provider's audits in July and August 2016 had given the service a rating of 'purple' which we were told meant the service had fallen below a red rating. The provider subsequently clarified that the audit related to the setting up and implementation of a new quality assurance framework relating to the effective running of the home. They told us the purple rating was as a result of a delay in transferring documentation from the old system to the new system, rather than being reflective of the quality of care provision.

However, we found the provider's audit system required improvement because they had not identified where they were in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, or identified the other areas where we found improvements were required. For example, their audit of accidents and incidents had not identified some incidents should have been referred as safeguarding concerns to us and the local authority. The provider had not recognised that the management and deployment of staff was not always sufficient to keep people safe. The provider's monthly audits from September through to December 2016 had identified gradual improvements in the assessment of the quality of care provided at Canning Court which coincided with the new manager taking up their post. The last audit had given the service an amber rating which indicated the provider acknowledged further improvements were required to ensure people received consistent high quality care.

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

Staff were complimentary of the new manager. They said the atmosphere in the home was good and staff

morale had improved. Staff described the new manager as 'supportive', 'approachable', and that they 'listened'. One staff member said, "The manager is always walking around, she is really friendly." Another told us, "The managers are really good here; they are 'on the floor' and about, not in the office. They are so approachable. I have been to [manager] on a number of occasions, they are really easy to talk to and if you raise it, it's confidential." This staff member went on to say, "I have massive confidence in the management." A member of nursing staff told us that improvements were being made under the new manager. They told us, "We know what's going on, communication is much better and staffing levels have improved. The manager listens and acts on what we say or explains why things can't happen." At the time of our inspection visit the manager was completing their application for registration with us.

Whilst staff were positive about the leadership demonstrated by the new manager it was clear they needed to be confident the new manager was going to stay so changes were sustained. The new manager recognised that staff needed stability in leadership to deliver high quality care and needed to feel valued. They explained, "We have got a core group of staff who are committed, hardworking and caring and concerned about the wellbeing of the people. I'm getting to know their skills and what motivates them. What they were asking for is consistency from my approach. They have all asked how long I am staying. Nobody had spent enough time to get to know them. It is the core team that stabilises Canning Court."

Staff told us there had been a very high turnover of staff at Canning Court. One staff member told us, "Staff here are coming and leaving, coming and leaving, no one is looking at why they are leaving." Another said, "On the whole the staff get along and work well together here. There have been a lot of changes, but everyone gets on. I don't know why there has been a turnover of staff, the culture here is positive." The PIR submitted by the provider confirmed that in the 12 months prior to September 2016, 42 staff had started working at the home, but 50 had left. The manager accepted that staffing had been a problem, mainly due to competition from other care homes in the local area. They told us that when they started working at the home there were no permanent nurses at night and the service was reliant on agency nursing staff to cover night shifts. The manager had successfully recruited to these posts and at the time of our inspection only had one nursing vacancy outstanding. However, some relatives felt the provider had not been supportive of the manager in maintaining staffing levels. They told us there had been staffing issues at another of the provider's homes a few miles away. In order to resolve the issue the provider had offered enhanced rates of payment to attract staff into those posts. This had resulted in some staff from Canning Court transferring to the other home which had created further staff vacancies in the home. Relatives had written to the provider expressing their concerns about the actions taken and the lack of thought about how this could impact on the quality and consistency of care provided at Canning Court. A meeting had been arranged for the area manager to discuss the concerns raised with a representative for the relatives.

The new manager had a strong background in delivering person-centred care and was committed to ensuring people received high quality personalised care from equally committed staff. They were open about the challenges they faced at Canning Court and explained, "There is no quick fix here and it will take time to change the culture."

The manager was keen to develop a strong senior team to drive improvement and had recruited a new clinical lead to provide support to the nursing staff. The clinical lead had been in post for five weeks at the time of our inspection visit. They told us, "I am here to support the nurses and update the care plans. We failed the internal audits which are RAG rated." We looked at the results of the care plan audit the clinical lead had completed in November 2016. We saw that none of the care plans had achieved a green rating and the majority had been rated as red. A subsequent audit carried out in December 2016 found improvements had been made in care planning and the completion of daily notes and supplementary records. A member of nursing staff spoke positively of the clinical lead and said, "We have a very good clinical lead. We are

having to sort out the care plans at the moment."

The manager had also appointed team leaders and senior care staff to provide leadership on shifts and improve communication between care staff, nursing staff and managers. The manager explained it was important to give senior staff the skills to carry out their role. Team leaders were undertaking a three day course in leadership and this training was to be offered to senior carers as well.

Twice a day the manager carried out a 'walk around' of the service to check on the delivery of care. One member of staff told us the manager was very visible and went on to say, "Especially in the morning, she will say hi to all the residents and hi to all of us." Each day there was a 'Take 10' meeting where the heads of department came together to discuss items such as any high risk clinical issues that had occurred over the last 24 hours and staffing. There were also other essential daily, weekly and monthly checks to ensure the smooth running of the service and to identify any issues that could effect the standards of care within the home.

People and relatives were invited to share their experiences of the service provided at Canning Court through a suggestion box in the reception area, an annual quality survey and regular meetings. The results of the 2016 survey were still being collated at the time of our inspection visit. We looked at some of the minutes of the most recent meetings. We saw that action had been taken following suggestions from relatives. For example, relatives had asked for photos of staff to be displayed so they knew who was on duty on each shift. We saw photo boards on each unit with photographs of staff, together with their job title. Relatives had asked for more activities and another activities co-ordinator had been recruited. Relatives wanted improvements in the meal time experience and at the time of our inspection visit the dining room facilities were being upgraded. People and relatives had been invited to a 'meal time experience workshop' to share their views and opinions on meal service within the home.

The provider is required to send us notifications so we are able to monitor any changes or serious issues within the home. During our visit we identified a safeguarding issue we had not been notified about, together with a serious injury notification. The manager told us the responsibility for submitting the notifications had been delegated to a senior member of staff who was no longer at the home. They assured us notifications would be submitted in future as required by the regulations. The ratings from our previous inspection visit were prominently displayed in the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Procedures and processes to keep people safe were not always followed or effectively implemented.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not robust, established and operated effectively to ensure people were consistently provided with a good quality service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The deployment and management of staff did not ensure that people using the service were kept safe at all times.