Premiere Health Limited

Cann House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The comprehensive inspection took place on the 9 and 10 July 2018.

When we inspected the service in September 2016 we found significant concerns in relation to people's care and the running of the service. The service was rated as Inadequate overall and was placed in special measures. A condition was placed on the provider's registration instructing them to provide the Care Quality Commission with a monthly report about how they were addressing the concerns raised and how they would improve and meet the regulations. We inspected the service again on the 16 and 17 May 2017 and found significant improvements had been made in all areas. Due to this improvement the conditions placed on the provider's registration was removed. We found some improvements were still needed in relation to medicines, care planning and leadership, however, we could see that these areas were being addressed and improvements were still being embedded into the culture and running of the service. We rated the service as Requires Improvement at the May 2017 inspection.

At this inspection we found improvements found at the last inspection had been sustained and further embedded in the culture and the running of the service.

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

The service provides accommodation and nursing care for up to 61 people. On the day of the inspection 47 people were living in the home. The service also provides assessment and rehabilitation to some people when they are discharged from hospital. This would normally be for a period of six weeks and is known as 'Discharge to Assess (DTA). At the time of the inspection the service had 10 DTA beds, and five were occupied. The assessment and rehabilitation of people staying in a DTA bed was overseen by a DTA team, which included physiotherapists and occupational therapists. We spoke with the DTA team during the inspection and their feedback is detailed within the report.

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

People now lived in a service with good leadership. The providers caring values and commitment to improvement were embedded into the culture and staff practice. People, relatives, external professionals and staff spoke very positively about the management of the service. The registered manager also had a committed and passionate attitude about the service, the staff, but most of all the people. Staff spoke of their love for the people they cared for, and their passion for working at the service.

Staff knew people well, and were able to tell us about their care needs and how they needed to be delivered. Staff were well trained and knowledgeable about people's health and social care needs and this was reflected in the practices we observed. People told us they felt their care needs were understood and well met by staff. However, some of the written information about people's care arrangements still required some further improvement to ensure the care being delivered continued to be personalised and consistent.

Nursing staff were available to oversee and support clinical practice, and individual staff members undertook specific training such as end of life care and moving and handling. All staff were valued and encouraged to share and develop their knowledge. For example, each month a staff member produced an information board about a certain area of care, such as oral hygiene and recognising signs of sepsis, and this was displayed in the main hallway for people, staff and visitors to see and gain information from.

People told us they felt safe living at Cann House. People were protected from abuse and avoidable harm because staff had been trained and knew what action to take if they suspected someone was being abused, mistreated or neglected. Staff were recruited safely to ensure they were suitable to work with vulnerable adults. The provider ensured the environment was safe for people to live in. Regular checks were undertaken and the equipment used by people was maintained to ensure it was safe and fit for purpose. People were protected by the provider's infection control procedures, which helped to maintain a clean and hygienic environment.

People who had risks associated with their care had them assessed, monitored and managed by staff to ensure their safety. People's safety was very important to the provider and staff. When things went wrong the provider learnt from mistakes and took action to make improvements. People received their medicines safely and staff undertook regular competency tests to help ensure they had the skills required to support people safely with their medicines.

People received an organised and coordinated approach to their health and social care needs. People had access to external healthcare professionals to ensure their ongoing health and well-being. The registered manager and provider also worked closely with the local social and healthcare services to support people to return home following a stay in hospital. Feedback from other agencies about the outcomes for people staying for a period of rehabilitation was very positive. Staff were also trained and skilled in providing good and dignified end of life care, which supported people to stay in the home during their last days and prevented re-admissions to hospital.

People were asked for their consent and staff acted in accordance with their wishes. Where people appeared to lack capacity, mental capacity assessments were completed and involved the person, their family and professionals in best interest decision making.

People were supported to eat a nutritious diet and were encouraged to drink enough. At the time of the inspection people were experiencing very hot weather conditions. Staff made sure everyone had access to fluids and monitored people's fluid intake to reduce any risks of dehydration.

People had access to a wide range of social opportunities. Relatives were welcomed and encouraged to join in social events. As well as responding to people's changing needs the service worked in innovative ways to enrich people's lives and experiences. Intergenerational experiences were promoted by inviting children from local schools to visit the home and to spend time with people and to join in events in the home. Two people had also visited a local school to join in with an event. This aimed to connect the generations and create a sense of well-being for both young and old alike. The activities coordinator had worked hard to build positive relationships with the local community, which they believed would impact positively on

people and help prevent social isolation.

The provider had robust quality monitoring arrangements through which they continually reviewed, evaluated and improved people's care. Complaints, concerns, feedback and the monitoring of accidents and incidents were used as an opportunity to learn lessons and improve the service.

We have made a recommendation about personalised care planning.

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 in the service. Risks associated with people's care were assessed, monitored and managed by staff to ensure people's ongoing safety and well-being.

People were protected from abuse and avoidable harm.

People were supported by staff who were available in sufficient numbers and who had been recruited following safe recruitment practices.

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

People were protected by safe infection control practices.

People lived in an environment which was well maintained and regularly to checked to ensure safety throughout.

Is the service effective?

Good

The service was effective.

People's care and support was based on legislation and best practice guidelines, helping to ensure the best outcomes for people.

People were cared for by staff who had received a high standard of training and support to meet their needs.

People were supported to eat a nutritious diet and to drink enough.

People had access to external healthcare professionals to help ensure their health and well-being was maintained. People received an organised and co-ordinated approach to their health and social care needs.

People lived in a service, which was well maintained and adapted when required to meet their needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by staff who respected and valued the people they cared for.

People were supported and given time to express their views so that those caring for them fully understood their wishes and preferences.

People's privacy, dignity and independence were respected in a compassionate, timely and appropriate way.

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

Is the service responsive?

Requires Improvement

Although improvements had been made some aspects of the service still required improvement to ensure they remained responsive to people's needs.

People's care plans were not in all cases personalised and did not always provide staff with sufficient information about how people wanted and preferred their care and support to be delivered.

People were supported to remain part of the community, follow their interests, and take part in social activities to improve and maintain their well-being.

People were supported at the end of their life to have a comfortable, dignified and pain free death.

People's concerns and complaints were listened to and acted on. People's complaints and concerns were used as positive learning to improve the service.

Is the service well-led?

Good

The service was well- led.

People lived in a service whereby the providers caring values were embedded into the leadership, culture and staff practice.

People, relatives, staff and external professionals all spoke positively about the leadership of the service.

People benefitted from living in a service where the provider and registered manager were committed to making and sustaining improvements and providing a high quality of care.

People and their families were encouraged to be involved in the development of the service.

People were supported to be part of the local and wider community to prevent isolation and to enhance their experiences and well-being.

People benefitted from a provider and registered manager who worked with external agencies in an open and transparent way.

People lived in a service which was monitored by the provider to help ensure its on-going quality and safety.

Cann House Care Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 9 and 10 July 2018. The inspection was unannounced. The inspection team comprised of one adult social care inspector, a specialist nurse advisor, a medicines 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 services for older people.

Prior to the inspection, 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 what improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, such as feedback we received from health and social care professionals and notifications. A notification is information about important events which the service is required to send us by law. This helped us with the planning of the inspection and enabled us to ensure we were addressing any potential areas of concern.

During the inspection we spoke with twenty five people who lived at the home, three relatives, the registered provider, registered manager and ten members of the staff team.

We looked at the care records of fifteen people receiving residential and nursing care. These records included, support plans, risk assessments, medicines records and daily monitoring forms. The medicines advisor looked at people's individual medicines records as well as records relating to the management of medicines held in the home. They also spoke to staff and observed as staff supported people to take their medicines.

We also looked at records relating to the running and management of the service. This included five staff files, recruitment records, training records and supervision contracts. In addition we looked at accidents and

incidents, safeguarding investigations, complaints, and quality monitoring systems. Quality monitoring records included health and safety audits, medicines audits, feedback from people and staff and other monitoring of the service.

During the inspection we spoke with three healthcare professionals. We also received feedback from Plymouth City Council Commissioning and quality team, and the Clinical Commissioning Group who had responsibility for overseeing people being supported with nursing needs.

Good

Is the service safe?

Our findings

At the inspection undertaken in September 2016 we found significant concerns in relation to people's safety. We asked the provider to take action to address the concerns and to meet the requirements relating to people's safety. We carried out a further inspection in May 2017, and found the provider had made significant improvements. Some improvements were still needed in relation to the assessment and management of risk, and time was still needed to fully embed the changes and improvements into the running and culture of the service.

At this inspection we found improvements had been made and people told us they felt safe. People said they felt safe because the environment and the people around them kept them safe. Comments included, "It is as good as a three star hotel, I am safer here than at home". Relatives told us they felt their loved ones were safe due to the "Safe and constant care they received". The provider and staff checked regularly to ensure people felt safe. A form was available in people's bedrooms with the title, "Do you feel safe and well cared for", and staff spent time sitting with people going through this information if required.

People who had risks associated with their care had them assessed, monitored and managed by staff to ensure their safety. Assessments and guidelines for staff were in place in relation to risks such as skin care, transfers, continence, falls and diet. Records included an assessment of the risk and guidelines for staff about how the risks needed to be monitored and reduced. For example, one person had risks associated with their skin. Guidelines had been provided by the Tissue Viability Nurse and these were understood and followed by staff. People had the correct equipment provided to prevent them from developing skin damage. Systems were in place to regularly monitor people's skin condition so that any action could be taken promptly if needed. Some people needed to be supported to be moved and transferred in a particular way. People were safe because staff undertook training in safe moving and handling, individual guidelines for people were in place, and equipment such as hoists, slings and wheelchairs were available and maintained to a high standard. People with known risks associated with health conditions such as Diabetes and breathing difficulties had specific care plans in place. It was noted that the quality of care plans did in some cases differ. For example, one person had a detailed plan in place describing the risks associated with diabetes, and how they needed and chose to be supported. However, another plan for a person with the same condition was not as detailed. Staff spoken to were aware of these people's risks and how care needed to be delivered. This was discussed with the registered manager at the time of the inspection and the importance of ensuring best practice across the service. Following the inspection the registered manager wrote to us and told us this issue had been addressed.

People were protected from abuse and avoidable harm. This was because staff understood the providers safeguarding policy and received training about what action to take if they suspected someone was being abused, mistreated or neglected. Staff spoke confidently about how they would protect people by raising their concerns immediately with the registered manager or senior staff, or with external agencies, such as the local authority safeguarding team or police. Staff were recruited safely to ensure they were suitable to work with vulnerable people.

People's individual equality and diversity was respected because staff received training on the subject, and knew people well. Examples were provided to demonstrate people did not face discrimination or harassment in relation to their sexuality. Staff had spent time with people to gain a better understanding in relation to their individual choices and how they preferred to be cared for and supported.

People were cared for by suitable numbers of staff, who supported them and met their needs. Throughout the inspection we found staff were available in all parts of the home, and although busy supporting people were easy to find at all times. People were positive about the numbers of staff available and all said that the staff knew them well, and understood how they chose and needed to be supported.

On the first day of the inspection it was noted that the call bell system was very busy, particularly during the morning. We observed one person had to wait in excess of ten minutes for the bell to be answered. We spoke to people about the call bell system. People said they did sometimes have to wait, but were very understanding and supportive of staff. Comments included, "We do sometimes have to wait a little while, but I understand staff are busy and they do check I am ok", and, "They can be very busy, but would usually check we are ok and tell us they will soon be back to help". The call bell system was discussed with the registered manager during the inspection. We were told a new call bell system had been installed since the last inspection, which had improved response times and helped how staff prioritised responses. The provider also undertook a regular audit of call bell responses and had made changes as a result of these checks. For example, the provider had reviewed staffing arrangements during the busy time of the day and introduced different methods of how staff responded to calls. The registered manager said they were concerned about our observations and that some people were still not having their calls answered in a timely manner. They said they would address this as a matter of priority, and would inform us of the action taken.

People received their medicines safely. People could look after their own medicines if it was safe for them to do this. Staff recorded the administration of medicines on an electronic system, which showed that people received their medicines in the way they had been prescribed for them. The systems for ordering and obtaining supplies had improved since the last inspection and people's medicines were available for them when needed. Medicines were given in a safe and caring way, and people were asked if they needed any medicines prescribed 'when required', for example pain relief. The application of creams and other external preparations were also recorded on the electronic charts. Staff told us they were looking at ways to record the directions for staff applying these preparations to make it easier for them to check how these should be applied, for example by using body maps. Non-prescription medicines were available, with a policy for their use, so that staff could respond to people's minor symptoms appropriately if necessary.

There were suitable arrangements for storing and disposal of medicines, including medicines requiring extra security. Storage temperatures were monitored to make sure that medicines would be safe and effective.

Staff giving medicines had competency checks to show that they gave medicines safely, and further updated training was being completed. There was a reporting system so that any errors or incidents could be followed up and actions taken to prevent them from happening again. Staff carried out daily checks on the electronic recording system to make sure medicines had been given and recorded correctly. Monthly medicines audits were also completed to check medicines were stored and recorded correctly. There were policies and procedures to guide staff on managing medicines and information about people's specific medicines was available.

People lived in an environment which the provider had assessed to ensure it was safe. Equipment used by people, such as hoists, wheelchairs and the lift were regularly checked and serviced in line with

manufacturing guidelines. A fire risk assessment was in place and regular checks completed of the fire system and equipment. People had Personal Evacuation Plans (PEEPS) in place to ensure emergency services understood how people needed to be evacuated in the event of a fire. A contingency plan was in place to help ensure people continued to be safe and cared for in the event of an emergency. The plan contained guidelines for staff and emergency contact details.

People were protected by the provider's infection control procedures, which helped to maintain a clean and hygienic service. Staff had completed infection control training. Protective clothing, gloves and aprons were available for staff when providing personal care. A monthly infection control audit was carried out, which included checks of equipment, staff practice and training requirements. We found the home to be clean and hygienic throughout.

Accidents and incidents were reported and the registered manager reviewed all completed forms to identify any themes or trends. A falls audit and analysis was completed monthly and action taken when required. For example, one person had an increased number of falls. Incident reports recorded this was due to them mobilising very quickly, rather than a medical condition. This had been discussed with the person's GP. Advice had been provided to staff about giving the person clear instruction and advising them to take things slowly, whilst also maintaining their independence when possible.

The registered manager worked hard to learn from incidents, near misses and mistakes. They said, "There is always a lesson to learn from incidents". For example, a concern had been raised where a mark on a person's skin had not been identified and addressed in a timely manner. The registered manager had undertaken an investigation. They had looked at the systems in place to see where these needed to be improved or reinforced to staff, to prevent reoccurrence and to ensure the best care is provided to people. The provider said the investigation had improved recording practices and staff awareness of changes in people's skin. They said they had also considered as part of the investigation the culture of reporting, acting on incidents and the importance of apologising when mistakes or omissions in practice may have occurred.

Good

Is the service effective?

Our findings

People, relatives and other agencies praised the skills of the staff team. People's comments included, "The staff are competent, I have no complaints". Relatives said they believed the staff were well trained and able to meet their loved ones specific needs.

Before people moved into the home an assessment was completed to help ensure the service was suitable and the person's needs could be met. The registered manager said the assessment was undertaken either by them, the homes clinical lead, or by the local hospitals 'Trusted Assessor', who had prior knowledge of the home and the services available. Some people moved into the home for a period of assessment after a stay in hospital. The provider would receive a copy of an assessment from the hospital and any questions regarding their care would be asked as part of the admissions process.

The provider had continued to embrace technology to improve people's care and communication. The electronic care and medicines system continued to be developed. Staff said they were finally 'getting to grips' with it and using it to improve the recording and monitoring of people's care arrangements.

Staff undertook regular training to help ensure people's care needs were met effectively. All new staff undertook a thorough induction programme, which include the completion of the Care Certificate for those staff who had never worked in care before. The Care Certificate is a nationally recognised qualification for care workers new to the industry. Staff had an on-going training programme and a training matrix was used to check when training had been completed, was needed or due for renewal. Training consisted of a mix of skills the provider considered essential for all staff, such as health and safety, safeguarding and infection control. In addition training was provided which was specific to certain people and staff in relation to conditions such as diabetic and pressure care.

Some staff had been given the role of being a champion in a particular area of care, such as, moving and handling and End Of Life care. This meant the staff member had the responsibility and allocated time to attend training sessions, gather information and roll out training and best practice information to the staff team.

Staff told us they felt well trained and supported to fulfil their role. A member of the care team said, "I have had moving and handling training and there is also a lead in this area of care so we can get support at any time". Two nurses said they had a good induction and regular supervision. They said they could see and discuss issues with the matron at any time. Other comments included, "There is always a nurse available to support and advise on practice. I have expressed a wish to do some teaching and they are supporting this". Staff demonstrated good knowledge and skills when carrying out specific care procedures, such as catheter care.

People's care and support was based on legislation and best practice guidelines helping to ensure the best outcomes for people. Nursing staff were supported by a lead nurse and undertook clinical training to help

assist with their ongoing competency and revalidation. Revalidation is the process by which nurses have to demonstrate continued knowledge and competence in order to retain their formal nursing registration with the Nursing and Midwifery Council (NMC).

People were supported to eat a nutritious diet and were encouraged to drink enough. People said the food was mainly good, with plenty of choice available. Comments included, "The food is absolutely fantastic, I always thank the chef, the meat is so tender". At the time of the inspection the temperatures were very high and people were experiencing very humid weather conditions. Staff ensured people had access to fluids, and drinks were readily available for people around the home. A staff member said, "Some people have their fluid intake monitored due to particular health conditions, but due to the recent hot weather we are monitoring everyone's intake and pushing fluids all the time".

Staff knew what people's nutritional needs were, and dietary care plans were in place to guide them and to highlight any risks. People who required assistance were supported and specialist equipment, such as coloured plates and specialist cutlery was available if required.

We saw people were able to enjoy their meals in a comfortable and pleasant environment. The dining area was large and bright. Tables were attractively laid with menus, table cloths and flowers. Meals were served at a good temperature and people were able to enjoy their meal unrushed with gentle classical music playing in the background. People who required assistance were supported in a respectful and dignified manner, by staff who meaningfully engaged with them and didn't suggest they were in a hurry or busy.

We saw people were regularly offered drinks throughout the day as well as cakes and snacks between the main meals. People with Diabetes had their food and fluids provided at the times required, and other agencies had been involved when people had been assessed as being at risk of choking. Staff were aware of these risks and followed any guidelines provided.

People received an organised and co-ordinated approach to their health and social care needs. We received very positive feedback from healthcare professionals in relation to the care of people discharged to the home for a period of assessment and rehabilitation before going home. A compliments letter was available in the home from a person who had stayed for a period of assessment. The letter stated, "Nothing was too much trouble, the staff were kind and patient, I would not be doing so well without their support". The healthcare professional who had received the feedback had also sent comments stating, "This for me is an excellent example of the discharge to assess (DTA) concept, working to achieve the best outcome for the client". The service participated in a local scheme to prevent people having a long stay in hospital and to support their rehabilitation to return home. This was known as Discharge to Assess (DTA).

People had access to external healthcare professionals to ensure their on-going health and well- being. Comments included, "I can see my GP whenever I want to". People's care records detailed a variety of professionals were involved in their care, such as community nurses, occupational therapists, GPs and Dieticians. One person's records confirmed they had input from a Tissue Viability Nurse in relation to skin care. Discussions with staff and monitoring forms demonstrated their recommendations had been implemented. A person with diabetes had been seen regularly by an optician and chiropodist. Staff were aware these checks were crucial due to risks associated with this condition.

People's legal rights were upheld. Consent to care was sought in line with guidance and legislation. The registered manager understood their responsibility in relation to the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards,(DoLS). People's care plans recorded their mental capacity had been assessed when required, and that DoLS applications to the supervisory body had been made

when necessary. There was a system in place to help ensure approved applications were reviewed prior to their expiry, which meant people were not at risk of being unlawfully restricted.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation Of Liberty Safeguards (DoLS). At the time of the inspection only one person in the home had an authorised DoLS in place. The registered manager was able to provide us with the documentation and a summary of what this meant in practice.

People's consent to certain aspects of care had been sought either at the point of admission or during their time in the home. In some cases consent had been documented and held on people's files. We saw staff asking for people's consent in relation to their daily care, such as before assisting them with their lunch or with their medicines. People had access to advocacy services if they had no one to act on their behalf. This helped ensure they did not face discrimination when making decisions.

People benefitted from living in a large and well maintained property with beautiful gardens and views over the countryside. Although the property is old with lots of original features, adaptations had been made when required to meet people's needs and individual requirements. The registered manager and provider undertook spot checks of the environment and a maintenance plan was in place to ensure the ongoing upkeep of the building and grounds. At the time of the inspection a new lift was due to be installed, and consideration was being given to improving staff parking and access. A new air conditioning system had also been installed in the treatment room as well as new manual handling equipment, which had been requested by some health professionals for new people moving into the service.

Good

Is the service caring?

Our findings

People were supported by staff who cared about them and put them and their needs at the heart of the service.

People said, "They are very kind, it is good here", "I am very happy here" and "I couldn't be in a better place". People said nothing was too much trouble, "The cleaners never moan and always carefully dust each of my many ornaments and nick-nacks". A relative said, "The manager came to visit us at home, she talked to me, I was very happy to bring my loved one here". Another relative said, "My loved one is thriving here. When they arrived they were too poorly to do anything. Now they come downstairs and take part in activities". When asked how the staff treat people the same relative said, "The staff are so lovely, it sometimes makes me cry".

Staff worked to understand how people were feeling and provided reassurance when required. One person told us, "When I was selling my house I was so worried about it all and worried they would throw me out. The matron explained everything and reassured me, they were lovely, they couldn't be better".

The atmosphere in the home was warm and welcoming. One person said the atmosphere was "One of the best" . Relatives described the home as 'homely' and 'family like'. We saw and heard lots of lovely interactions between people and staff, and staff went about their work with a friendly smile. Even when staff were busy they ensured time was given to people to have a little chat and to check people were ok. We saw staff getting down on their knees to have eye contact with people when they were talking, and holding people's hands when they considered some gentle reassurance was needed. Staff spoke compassionately about the people they supported and told us, "I love my job", "I love working with people and caring" and "knowing that I have made a difference to somebody's life. I am here for the resident and nobody else".

Staff cared about people and checked regularly that they were comfortable and happy. People said, "They are very busy, but they always pop in and check I am ok, and give a friendly smile and a wave as they are passing". On the day of the inspection the weather conditions were very hot and humid. Fans had been placed in bedrooms and hallways to help ensure people remained cool and comfortable. Staff checked regularly that people were comfortable with where they were sitting, altering seating, curtains and blinds to ensure people's comfort.

Staff knew people well and had a good knowledge about people's backgrounds and particular interests. For example, one person loved football and was enjoying watching the World Cup which was on the television at the time of the inspection. The sitting room had been decorated with flags and a staff member had bought the person an England tee shirt, which staff said they were delighted with. We met this person who was positioned with prime view of the television wearing their England tee shirt and a very big smile.

People's independence was respected in a compassionate, timely and appropriate way. For example, we saw one person mobilising using their walking frame. A staff member walked slowly behind them, keeping their distance whilst reminding the person about their safety. The person clearly appreciated this interaction

and reassured the staff member gently that they were safe and managing "just fine".

Staff were patient and gave people time to express their views and to understand what was happening when care was being provided. For example, we saw staff supporting some people to eat. Staff made sure they did not rush and talked to the person about what they were eating and if they liked it. Staff wore different coloured tabards, which helped identify to people if they were care staff, a nurse or a member of the housekeeping team.

People's privacy and dignity was promoted. Staff used their knowledge of equality, diversity and human rights to support people with their privacy and dignity in a person centred way. People were not discriminated against in respect of their age, gender, sexuality or disability. Staff knocked on people's doors before entering and ensured their privacy and dignity when personal care was being provided. One person told us they suffered from a fear of confined spaces. They said the staff understood, and made sure their door was open at all times. They said staff also worked hard to ensure their privacy and dignity was maintained.

People's family and friends were warmly welcomed, with no visiting restrictions. Everyone agreed that visitors were made welcome and one visitor brought a dog in to visit. All people said their visitors liked the home and staff, particularly the beautiful setting. All visitors were offered refreshments whilst they were visiting.

The registered manager monitored the caring culture by being present and visible within the service. The registered manager demonstrated a caring approach, and was a role model for staff.

Requires Improvement

Is the service responsive?

Our findings

At the inspection undertaken in September 2016 we found significant concerns in relation to the planning of people's care, activities and the handling of complaints. We asked the provider to take action to address these concerns. We carried out a further inspection in May 2017, and found the provider had made significant improvements. Some improvements were still on-going in relation to care planning and time was still needed to fully embed the changes and improvements into the running and culture of the service.

At this inspection we found improvements had been maintained in relation to complaints and activities and the care planning system had continued to be developed. We found some improvements were still needed in relation to care planning to further ensure people's care was consistent and personalised.

The registered manager carried out a pre- assessment of people's needs prior to them moving into the service. This information was then used to help the service develop the person's plan of care. People staying in the home for a period of rehabilitation following a hospital admission had their needs assessed by the Discharge to Assess Team (DTA). In this case people's care plans were jointly developed and reviewed by staff in the home and the hospital team. This helped ensure people's progress was reviewed and the outcomes expected met within the required timescales.

People's care records contained a range of information about their health and social care needs. Some of the information was available in written format as well as in more detail on the homes electronic care system. The registered manager said the written files were available in the event of a problem with the homes computer system. People's care plans covered different aspects of people's health and social care needs, any potential risks and how people needed to be supported. It was noted that the quality of people's care plans differed across the service. Some people's plans were personalised and described in good detail about how people chose and preferred to be supported. For example, one person had a particular health condition, and the plan clearly described how the person chose to be supported and detailed information about how their care should be delivered by the home and other agencies. However, some other plans were not as personalised. For example one plan stated the person needed total support in the bathroom, but did not say how that care should be delivered or the person's specific routines and preferences. People's plans in relation to their medicines were not in all cases person centred. For example, staff told us they used various methods to reduce one person's anxiety and to prevent the over use of medicines. Although staff were able to tell us about these methods, they were not documented as part of the person's care plan.

All the staff we spoke with were knowledgeable about people's care needs and were able to tell us about people's routines and how they chose and preferred to be supported. Most people said that staff had a good understanding of their needs and how they wanted to be supported. However, one person said they liked to be up and dressed early in the morning so that they could go downstairs for the morning activities. They said there had been occasions when staff had not got them ready in time. They were very understanding of the staff, but said they hoped it wouldn't happen too often. We looked at this person's care records and saw that their daily routines and preferences had not been documented. The absence of personalised care planning across the service could mean that people's needs would not be met consistently and in a way they chose

and preferred.

A system was in place to review and monitor people's care arrangements. There were detailed handover meetings, which highlighted to staff where there had been changes during the day and night. People's support plans were also reviewed on a monthly basis and any changes made to help ensure information remained accurate and up to date. Multi-agency meetings took place every week to discuss the progress of people staying in the home for a period of rehabilitation and assessment. These meetings consisted of staff from the home as well as health professionals including Occupational Therapists and Physiotherapists. People's progress was discussed as well as any support and training required by the staff team.

A wide range of social opportunities were available to people. The home had an activities coordinator and two volunteers who helped with the planning and delivery of activities and social opportunities in the home. People without exception spoke highly of the activities coordinator. Comments included, "She is wonderful", "So kind, I join in all the activities". Large notice boards were visible around the home, with information about activities and weekly events such as, church services, hairdresser visits and coffee mornings. The home had its own chapel, and people were able to choose if they wanted to attend planned church services or use the chapel for quiet time, prayer and reflection.

Throughout the inspection we observed a friendly, busy but calm atmosphere. The home was large and spacious, which meant people had space to either sit on their own, meet with family and friends or join in activities. We saw some people enjoying a quiz and others singing along to a visitor playing the piano. Some people were sat in the conservatory enjoying a cup of tea with their visitors and others were sat outside in the garden enjoying the sunshine and a chat with staff. People who spent time in their rooms said they were able to occupy their time and had regular visits from staff and the activity coordinator.

Relatives were welcomed and encouraged to join in with social events. Good links had been formed with the local and wider community, which helped promote people's well-being and prevent isolation. A summer fayre had been organised and family and the local community had been invited to attend and join in with the planning.

One person told us their family was able to visit at any time. They said, "Oh yes, of course. I had a lovely birthday celebration with all my line dancing friends. Unknown to me all my family came, my daughter and grandchildren and they made me a cake. The matron organised it all".

As well as responding to people's changing needs the service worked in innovative ways to enrich people's lives and experiences. Intergenerational experiences were promoted by inviting children from local schools to visit the home, to spend time with people and to join in events in the home. Two people had also visited a local school to join in with an event. This aimed to connect the generations and create a sense of well-being for both young and old alike.

The service also worked closely with local health and social care providers to respond to the changing needs of local people. For example, the service participated in a local scheme to prevent people having a long stay in hospital and to support their rehabilitation to return home. This was known as Discharge to Assess (DTA).Feedback from healthcare agencies was positive about this partnership working and praised the home for the positive outcomes people had experienced from the care provided.

We looked at how the provider complied with the Accessible Information Standard (AIS). This is a framework put in place from August 2016, which made it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We saw some information

about the service had been provided to people in a range of formats. For example, the daily menu was available in pictures as well as writing. Staff said they spent time with people if they needed them to read information to them such as their care plans or other information about the service. The activities coordinator had recently purchased new audio books and large print hymn books for people with sensory impairment.

People were supported to experience comfortable and dignified end of life care. A senior staff member was the End of Life Champion and was in the process of undertaking specialist training, which focussed on supporting people's end of life care and preventing an admission to hospital. One of the nursing staff had also completed their end of life six steps training at their previous employment and was keeping their training up dated. Six steps training is a locally accredited end of life training scheme approved and delivered by local hospice services. The staff member attended a meeting every three months and fed back any training, best practice and local initiatives to the staff team.

We saw some of the compliments the home had received when end of life care had been delivered. Comments included, "Exceptional care, contributed to ensuring [name] were as cheerful and comfortable as they could be in their final months", and "Thank you for caring for our dad for the last three and a half years and for attending his funeral".

People's comments and complaints were viewed positively, and used to help improve the quality of the service. A copy of the homes complaints procedure was available in the reception area of the home and people also received a copy. Although some people said they could not remember seeing the complaints procedure, people did know who to speak to if they had a concern and said they would be listened to. The registered manager showed us some complaints they had dealt with and the actions taken as a result of the issues raised. The registered manager said they dealt with complaints positively and used them to learn and improve the service.

We recommend that the service seek advice and guidance from a reputable source, about personalised care and care planning.

Good

Is the service well-led?

Our findings

At the inspection undertaken in September 2016 we found significant concerns in relation to the running and leadership of the service. We asked the provider to take action to address these concerns. We carried out a further inspection in May 2017, and found the provider had made significant improvements. However, at the time of the May 2017 inspection it was still too early to judge if the improvements would be sustained.

At this inspection we found improvements in the leadership and management of the service had been sustained and the service was well-led.

People, relatives and other agencies spoke very positively about the leadership of the service. People said, "There is always someone around to talk to, I know they would deal with anything if I had a problem". A relative said, "The managers have been so kind to us, and reassured us when we needed it".

Staff said they felt the service had continued to improve and "Go from strength to strength". Other comments from staff included, "It is so different now, so relaxed, a much nicer place to work", and "We have learnt lessons from the last inspection, there is now more of a culture of learning and improving".

The service had a registered manager. They felt well supported in the role by the provider and other senior staff. The registered manager set clear expectations of the high standards expected, with a focus on continuous improvement. Throughout the inspection the registered manager was open to any discussions regarding best practice and improvement. Immediately following the inspection the registered manager wrote to us with an action plan about how they had addressed or intended to address any practice issues raised during the inspection. This included, ordering a visual activity board, and making changes to the way the homes newsletter was provided to people to ensure they met the new Accessible Information Standard.

People benefitted from a registered manager who worked with external agencies in an open and transparent way and there were positive relationships fostered. We read feedback the service had received from other agencies, which stated, "Extremely impressed with the work you have done, and the whole culture of the service felt lovely. Both staff and residents appeared happy, content and well kept". The registered manager and provider also worked closely with the local social and healthcare services to support people to return home following a stay in hospital. Staff were also trained and skilled in providing good and dignified end of life care, which supported people to stay in the home during their last days and prevented re-admissions to hospital.

The provider and registered manager had a committed and passionate attitude toward the service and the staff, but most of all the people. They had worked hard to address the concerns raised at previous inspections and to maintain high standards of care. This had included making improvements in their quality auditing processes and reviewing their own systems, such as training, roles and responsibilities and recruitment. The registered manager and management team had also worked closely with the local authority and clinical commissioning team to help ensure improvements were maintained.

The provider promoted a very positive culture that was open, inclusive and empowering. The homes Statement of Purpose said that the service "Strives to enhance our residents' quality of life by placing emphasis on, Involvement, choice, respect, dignity and independence. Above all we want to create a homely atmosphere, where family and friends are always welcome, and where residents can remain as independent as possible, safe in the knowledge that their care is foremost in the minds of staff". These values were spoken about by staff and seen in their work. Comments included, "It is all about residents first". Staff spoke passionately about their work and about the meaningful relationships they had with people and families. Comments included, " I love working here, it's a good team and a good atmosphere"

The provider had worked hard to restore and maintain good links with the local community. The registered manager said they understood the local community had lost some trust in the home following concerns raised at previous inspections. They said they understood this response, but considered it very important to rebuild that trust and to prevent people in the home being isolated from their community. The activity coordinator attended a local community forum and local residents had been involved in events in the home such as the summer fayre, church services and school visits.

People and relatives were encouraged to be involved in the development of the service. Residents meetings were held each month and an action plan written to address any issues raised. At a recent meeting one person requested a necklace call bell to make contacting staff easier. The provider had purchased this for the person as well as several others in case further requests were made. Feedback was sought from people and their families and the provider acted on information they received. For example, following a recent survey the communal lounge had been redecorated to make it brighter and more welcoming as requested.

All the staff we spoke with said they were well supported by the provider and management team. Staff were made to feel valued members of the team, and their contribution was encouraged and recognised. For example, a display board was situated in the entrance to the home. A staff member each month had been required to make a display covering a topic of interest. Each letter of the alphabet was used, such as 'O' for Oral healthcare. The staff member researched the topic and created an informative display board for people, staff and visitors to view. Other topics covered included, sepsis, nutrition, and aspiration. Staff were keen to show us examples of this work and said it had been very positive and informative for everyone.

Management and staff were clear about their roles and responsibilities and everyone saw themselves as having a part to play in delivering a good quality service. For example, staff had delegated lead roles, such as infection control, first aid, tissue viability and end of life care. This meant individual staff had responsibility for maintaining their knowledge and skills in a particular area and were then able to train, advice and ensure best practice amongst the whole staff team.

The registered manager kept their ongoing practice and learning up to date to help develop the team and drive improvement. They attended regular meetings with the local authority for services that had a rating of 'requires improvement'. The registered manager said these meetings had been important as they had met with professionals and other providers to discuss best practice, improvements and maintaining high standards of care. They also attended Plymouth City Councils Dignity in Care Forums and an on-line outstanding manager's forum. They said these discussions helped them consider practice and improvements. For example, following a recent meeting the registered manager introduced a risk assessment as part of the recruitment process for any new staff that previously had a criminal conviction. This would further ensure people were cared for by staff who were safe to work with vulnerable people. The registered manager also informed us that they had requested to register on the leadership and management course with Plymouth City Council and to act as an Ambassador as part of a new Plymouth City Council 'Proud to Care' initiative, promoting health and social care in the local community.

The provider and registered manager were open and transparent and admitted when things went wrong. They demonstrated their understanding and recognition of the Duty of Candour. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong. The provider notified the Commission of significant events which occurred in line with their legal obligations. For example, regarding safeguarding concerns, deaths and serious injury.

People lived in a service which was monitored by the provider to help ensure its on-going quality and safety. The providers governance framework helped monitor the management and leadership, as well as the on-going quality and safety of the care people were receiving. For example, systems and processes were in place such as accidents and incidents, environmental, skin care and nutrition audits. These systems helped to promptly highlight when improvements or action was required. Management meetings took place to discuss the ongoing compliance of the service and action plans were produced to address any issues raised. This helped to ensure suitable progress was being made and/or tasks completed.

The service had robust arrangements in place to help ensure people's private and confidential information was protected and kept safe.