# Inspection Report

***We are the regulator:*** *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

# Coundon Manor Care Home

1 Foster Road, Coventry, CV6 3BH

Tel: 02476600860

Date of Inspection: 16 June 2014

Date of Publication: July 2014

We inspected the following standards as part of a routine inspection. This is what we found:

| | |
|---|---|
| **Care and welfare of people who use services** | ✖ Action needed |
| **Management of medicines** | ✖ Action needed |
| **Safety, availability and suitability of equipment** | ✖ Action needed |
| **Staffing** | ✖ Action needed |
| **Assessing and monitoring the quality of service provision** | ✖ Action needed |

## Details about this location

| | |
|---|---|
| Registered Provider | Priory Elderly Care Limited |
| Registered Manager | Miss Zoe King |
| Overview of the service | Coundon Manor provides nursing care for up to 74 frail elderly people including those who have dementia. |
| Type of service | Care home service with nursing |
| Regulated activities | Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury |

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*When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.*


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## Summary of this inspection

### Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

### How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 16 June 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and were accompanied by a pharmacist. We reviewed information sent to us by commissioners of services, reviewed information sent to us by other regulators or the Department of Health, talked with commissioners of services and talked with other regulators or the Department of Health.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

### What people told us and what we found

This service was inspected by four inspectors including a pharmacist inspector and an inspection manager. The inspection focused on concerns we had received about the service. The inspection covered parts of the night and day shifts. This was to enable us to see how people were being cared for and supported across the whole day. It was also to enable us to talk with a wide range of staff, people who used the service and their relatives or friends. Many of the people who lived at Coundon Manor were not able to tell us about their experiences of the home. We spoke with six people who lived at the home, two relatives, five nurses, eleven care assistants, a cleaner and a kitchen assistant. We also spoke with management staff.

We looked at five outcomes to answer the following five questions. Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

Below is a summary of what we found. The summary is based on our findings during the inspection, speaking with people who used the service, the staff supporting them and from looking at records. If you wish to see the evidence supporting our summary please read the full report.

Is the service safe?

People we spoke with were positive in their comments about the service but we found

improvements were needed in the care and support being provided.

People were not always involved in their care. We saw people's care records were not always accurate or sufficiently detailed to make sure people received the care they needed.

Staff had received or were booked onto training about the Mental Capacity Act. This was to improve their understanding of how to support people who lacked mental capacity to make decisions about their care and treatment. The manager told us further work was needed to check if any Deprivation of Liberty Safeguards (DoLS) applications needed to be made.

Effective systems were not in place to make sure staff learned from events such as accidents and incidents, complaints, concerns and investigations.

We found staff were not always knowledgeable about people's needs. We were told by staff that they did not always have time to read care plans. We found the number of staff available to support people and the way staff were organised was not always effective to keep people safe.

There were ongoing problems with people's medicines not being available. We were told this was primarily due to problems in communication between the doctor's surgery and the supplying pharmacy. Although we acknowledged the problem involved a number of agencies, effective action had not been taken to resolve it. We found that people's medicines were not always available to give to people as prescribed. This increased medicine safety concerns. We found appropriate arrangements were not in place to manage the risks associated with the unsafe use and management of medicines.

Is the service effective?

We saw there was a process to assess risks associated with people's care. We found this process was not being managed consistently. We found in particular risks associated with people's nutrition were not always effectively managed.

People had access to a range of health care professionals to support their care needs, some of which, visited the home.

We found some of the equipment needed to support people's needs was not readily available.

Is the service caring?

We saw staff were attentive to people's needs throughout our inspection. We saw some staff were kind and friendly in their approach. Others were task orientated and seemed rushed and unable to spend time with people. We spoke with a number of people who used the service. People told us they were satisfied with the care and support they received. One person told us, "I'm very comfortable and well looked after."

Is the service responsive?

People were able to participate in social activities within the home and within the local community. One person told us, "They throw balls and do painting." We saw social activities being undertaken on the day of our inspection.

There was not an effective system in place to manage complaints. This had been identified and the new management team were in the process of addressing complaints received.

We found systems and processes were not in place to analyse accidents and incidents to identify any preventative measures required.

We saw people were able to access help and support from other health and social care professionals when necessary.

Is the service well led?

At the time of our inspection the manager named on this report was no longer in post. A new manager had been employed and was to complete the CQC registration process.

We did not see there was an effective system to monitor the quality of care and services provided. We were told about plans in place to address this. These plans included the implementation of quality audits of the service.

We saw there was a new management team in place at the home. We saw actions were in progress to make improvements across the home. Staff were positive about the actions that the management team had taken since they had been in post.

You can see our judgements on the front page of this report.

## What we have told the provider to do

We have asked the provider to send us a report by 23 July 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Commissioning. We will check to make sure that action is taken to meet the essential standards.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

## More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

## Our judgements for each standard inspected

**Care and welfare of people who use services** ✖ Action needed

**People should get safe and appropriate care that meets their needs and supports their rights**

### Our judgement

The provider was not meeting this standard.

People did not always receive care and treatment in accordance with their needs to maintain their health and welfare.

We have judged that this has a major impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

### Reasons for our judgement

People were not always involved in the planning and delivery of their care. Care plans were not signed to demonstrate people had read and agreed to them. Care plan evaluation sheets did not make reference to staff having discussed people's care with them. We found blank 'All about me' forms on the files. This meant there was no information about people's backgrounds, hobbies and important events on their files. This information can help staff in delivering person centred care to maintain people's health and wellbeing.

People we spoke with were generally positive in their comments of the home. They told us, "I'm very comfortable and well looked after." "It's grand."

We found care and treatment had not always been planned and delivered in a way that was intended to ensure people's safety and welfare.

We looked at six people's care plans. We found care plans did not accurately reflect people's care needs. We also identified that risk assessments, nutritional plans and mobility assessments did not match people's health needs. For example, we looked at a care plan for a person who was at risk of malnutrition and was underweight. This showed the person required a soft food diet. We spoke with the cook about this person. They told us the person had a normal diet and on the day of our inspection had meat, mashed potatoes and vegetables. The cook told us: "I know this is information is out of date, I need to get it updated."

We looked at a care file for a person who had diabetes to see how this health condition was being managed. We did not see a specific care plan to manage this condition but saw there was an eating and drinking care plan. This did not mention the person had diabetes

or indicate any risks associated with diet which could lead to health complications. A nutritional assessment had been completed but this did not mention the person had diabetes. Many people with diabetes need treatment to control the amount of sugar in their blood. We saw the person had been prescribed medication to control their blood sugar levels but they had not been receiving it for a number of days because it had run out. This meant the person's diabetes was not being appropriately managed to maintain their health.

We found a number of people had not received medications to treat their health conditions. This included medicines for infections as well as to manage symptoms associated with dementia.

We looked at the care file for a person who had sore areas on their feet, glaucoma (an eye condition) and dementia. We saw the person had been refusing the medicines prescribed to treat their health conditions. In response to this, an agreement had been sought from the doctor and the person's relative to administer some of the medicines covertly. This is where medicines may be hidden in food or drinks. This should be managed in a way that does not impact on the person's food and fluid intake. For example, putting it in an additional item of food over and above their usual meals.

We saw the care records stated two medicines could be added to the person's porridge. Staff told us the person could taste the medicine regardless of what they put it in. We saw between March 2014 and June 2014 the person had lost a significant amount of weight. In March they weighed 65.7kg (10 stone 4lb) and in June 51.70kg (8 stone 1lb). This meant the person had not been consuming sufficient nutrition to maintain their weight. There was an instruction for the person to be weighed weekly but the dates showed this did not always happen weekly. There was an instruction for "extra calories" to be added to the person's meals. Staff told us the person was not given anything different to anyone else. We did not observe the person was given any additional snacks during our visit aside from those given during the morning and afternoon trolley rounds.

Within the care records we looked at, we saw two people wore glasses. We did not see either person wearing their glasses on the day of our visit. We observed one of these people ask a member of staff if they would be "kind enough" to find their glasses. The staff member responded they would. We did not see the person had been given their glasses until the end of the day. A staff member told us and we observed that one of the lenses was missing so the person could not see out of their glasses properly. The staff member told us they spent "a lot of their time" looking for glasses and slippers for people. This meant we could not be confident people always had their glasses to help them see well and help reduce the risk of them falling.

We saw a member of care staff had a list of people detailing what drinks they preferred. When asked what would happen if someone did not like the drink they were given, the care staff member told us they would give the person something else. We saw people were given drinks in different types of cup to suit their needs.

When we looked at a care file for one person, we saw advice from a health professional that stated the person required a thickener in their drinks. This was to help them swallow without choking. We saw care staff added a thickening agent to the person's drink which demonstrated this advice was being followed.

We looked at a care plan that identified a person had a stroke and had weakness to one

side of their body. We found conflicting information within the care records regarding which side the person had reduced strength. This meant staff may not have an awareness of the person's weak side to ensure they compensated for this when delivering care.

We spoke with three staff members and asked them to explain to us the care needs of people whose care records we had seen. We found staff knew limited information about the care and support people required. For example, we found staff were required to reposition people in bed to reduce the risk of them developing sore areas. We saw staff completed reposition charts but they were not aware of the frequency of turns or the positions people should be moved to. This placed people at risk of receiving inappropriate care and treatment because staff did not know the levels of support people required.

We asked three staff how often they looked at a person's care plan. Comments staff made were, "I haven't read one since last year." "I don't get chance." This meant there was a risk people received care from staff who did not know what peoples' individual needs were.

We observed one person had dried blood on their ear. We asked the nurse about this but they did not know about it. A second nurse told us there had been an ongoing problem with this person's ear. We looked at the person's care records. There was no information about the problem and how this should be managed. We saw the care records had last been reviewed in April 2014. This meant the person's records did not accurately reflect their health needs.

During the day we saw people in the elderly frail lounge engaged in different activities. Some people were supported by the activity coordinator to paint national flags in support of the World Cup. One person told us they enjoyed painting. We heard music played in the lounge and asked people if they were enjoying listening to it. Most people told us they had not requested it. A staff member told us they were, "Very limited to our CD collection. The last one kept stopping." On the dementia unit the television was on in the lounge for most of the day. We saw people's nails were cleaned and filed by a staff member. The staff member spoke with people as she worked her way around the lounge and we saw people enjoyed their interactions with her.

At lunch time we saw people were supported to the dining rooms on both floors. People were given a choice of cold drinks. We saw staff asked some people if they would like an apron to cover their clothes. We saw some people had plate guards to help them eat their meals independently.

Staff told us they supported some people to eat in their rooms following the lunch service in the dining rooms. Staff told us some people ate a pureed diet if they had difficulty swallowing. We were told about one person who had Parkinson's Disease which resulted in them trembling sometimes when they ate. We saw a staff member support this person throughout their meal.

We saw the hot food choices on the food trolley were gammon or quiche with boiled or mashed potatoes and broccoli. We saw there was a separate pudding for people with diabetes. We observed the lunchtime experience in the elderly frail dining room. We saw one member of staff took the time to speak with most of the people eating their meals. They supported one person to eat their main course. We saw the other care staff did not engage people in conversation and their interventions were only task orientated, for example, to ask if they wanted quiche or gammon. In the dementia unit we saw staff were task orientated and the mealtime was not a relaxed and enjoyable experience for people.

We saw gravy had been put on the meals with quiche and people had not been asked if they wanted it. We saw one person would not eat their meal. When this was mentioned to a member of staff, it was changed for one without gravy. The person then started to eat it. One person was fed their meal one spoonful after another before they had the opportunity to finish what was in their mouth. This was not dignified and was too fast a pace for the person to eat properly. We reported this to the manager.

We saw people finish their meal, get up and leave the dining rooms and staff did not speak to them.

When it was time for the evening meal we saw a negative interaction between a staff member and a person who had been given a meal in their room. A meal was placed down on a table in front of a person and the staff member stated "food" and left. When the staff member was questioned if the person needed any support to eat we were told the person did not need support. The staff member then went back into the bedroom to raise the head of the bed to make the sure the person was in a comfortable position to eat.

The manager told us that none of the people who lived at Coundon Manor had been subject to a Deprivation of Liberty Safeguard (DoLS). This relates to people who cannot make their own decisions about their treatment and/or care because they lack the mental capacity to do so. The manager told us the process for determining capacity and the need for any DoLS applications was under review. This was due to a recent ruling by the Supreme Court which could mean people who were not previously subject to a DoLS may now be required to have one. Staff had some awareness of the Mental Capacity Act and understood people may need to be supported in making decisions if they lacked mental capacity.

**Management of medicines** ✖ Action needed

**People should be given the medicines they need when they need them, and in a safe way**

## Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider was not ensuring that appropriate arrangements were in place to manage medicines.

We have judged that this has a major impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

## Reasons for our judgement

A CQC pharmacist inspector visited the home to check medicine safety. We looked at how medicines were ordered, obtained, stored, administered and handled. We looked at three medicine storage rooms including the medicine administration records for all people living in the home. We spoke with five members of staff. We found areas of concern with medicine safety.

The management team told us there were ongoing problems in obtaining people's medicines. One nurse told us, "The main problem is with this new electronic prescribing system, which means we are not in the loop anymore and don't see the prescriptions to check them." We found the arrangements for ordering and obtaining medicines did not ensure people's medicines were available to give. We found eleven people did not have one or more of their prescribed medicines because they had not been ordered and delivered in time. It was of concern that six people had not had their medicines given to them for seven days. This meant people were at risk of not being given their prescribed medicines to treat diagnosed health conditions.

Medicine administration records were not always accurately completed to document if people had been given their prescribed medicines. We noted there were gaps on five people's Medicine Administration Record (MAR) charts. This meant it was not possible to determine if they had been given their prescribed medicine. This was because the MAR charts had not been signed or a reason documented to explain why the person had not been given the medicine. It is important that medicine records are completed as this is the only record to show that people have been given their medicine at the prescribed times.

We looked at the MAR charts for two people prescribed a medicine that needed to be carefully monitored in order to make sure that they were given a safe dose. Arrangements were in place to ensure that accurate medicine stock checks could be done. This meant we could determine that they had been given the correct prescribed amount of this medicine.

Supporting information on how people preferred to be given their medicines was available and easy to follow. We saw documentation detailing known allergies on people's medicine records. We looked to see if nursing staff had supporting information on how to safely administer medicines. We found six people were prescribed medicines to be given 'when necessary' or 'as required' for agitation or anxiety. We found there were no procedures available to inform staff under what specific circumstances the medicine could be given. This is particularly important to provide guidance to staff who are not familiar with a person's individual behaviour and also when people are not able to communicate verbally.

Medicines were stored in locked and secure storage rooms. We found the keys were held by the nurse in charge. Daily temperature records were available for the medicine store rooms and medicine refrigerators. The temperature records showed medicines were stored within the recommended temperature ranges for safe medicine storage. We found that overall medicines were stored neatly which made it easy to locate people's medicines.

**Safety, availability and suitability of equipment** ✖ Action needed

**People should be safe from harm from unsafe or unsuitable equipment**

## Our judgement

The provider was not meeting this standard.

Systems were not in place to ensure there was sufficient equipment consistently available in good working order which staff could use to support people appropriately.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

## Reasons for our judgement

Prior to our visit to Coundon Manor we were made aware of a concern from the Local Authority commissioning officers that there was insufficient equipment available in the home to support people appropriately.

During our inspection we found the provider had taken some action to respond to the concerns raised about equipment. We found some items of equipment had been placed on order.

We found during our inspection there was no clear process in place which demonstrated how equipment within the home was organised and managed. It was not clear how staff were made aware of how to use specialist equipment, particularly agency staff, and what process was in place to make sure all equipment was regularly cleaned.

On the day of our visit we checked the availability of equipment, and where appropriate, if this was working. This included:-

Walking frames and wheelchairs
Slide sheets for moving and handling
Suction machines
Hoists and availability of slings
Equipment for catheter usage
Nebulisers – a drug delivery system that creates a mist of medicine, which is then breathed in through a mask or mouthpiece.
Specialist mattresses and pressure cushions

We saw there was a good supply of gloves, aprons and wipes for staff to maintain good infection control practices.

We saw a set of weighing scales that were in working order so staff could monitor people's weight and ensure this was being maintained.

Walking frames we observed were clean. A staff member told us they cleaned them as well as the wheelchairs when the need arose. We saw all wheelchairs had footplates on them to keep people safe when moving around the home. We were told there was a maintenance person who checked the wheelchairs every four weeks to make sure they were safe.

We saw there were slide sheets available within the home but there was not one in each of the rooms for those people that needed one. The manager told us additional slide sheets were on order and staff confirmed this so these could be made available in people's rooms. Staff told us they located slide sheets when they needed them.

We saw a suction machine was available on the elderly frail unit. This was being kept in the treatment room for emergency use. We saw when this was tested dirty liquid came out of it. This suggested the machine was not being regularly checked and cleaned. The nurse made arrangements on the day of our visit for this to be cleaned.

A nurse confirmed there was sufficient catheter equipment available such as urine bags and stands for those people who had a catheter. We were told the home had run out of 'bladder wash' the week before but this had been re-ordered and received. This suggested there may be an issue with stock control. Stock levels should be regularly checked to make sure they do not run out of essential products.

We saw on the elderly and frail unit there were two hoists available but only one hoist was in use. Staff told us, "Night staff should make sure it is charged, but it never is." Staff said this caused them concerns because people waited longer to be transferred than was needed.

On the dementia unit staff told us they needed more moving and handling equipment to support people. This included a second hoist due to the number of people that needed to be moved using a hoist.

Following discussions with staff, we identified equipment that had been reported to the maintenance person for repair. This included a bed which would not elevate and a mattress pump that was not working. It was found the mattress pump had not been plugged in by staff and was, when checked, in working order. The bed that would not elevate we were told required a minor and straightforward adjustment. This information suggested staff were not fully aware of how to use specialist equipment within the home. We established the person in bed had not been able to elevate the top part of the bed over the weekend due to the staff on duty not being aware of how to adjust it.

Staff knew each person should have their own slings to use with the hoist (a toilet sling and a full sling). They told us these should be marked with the person's room number and kept on the back of their room door. Staff on the first floor were clear this system was not in place. We saw a sling on the hoist in the assisted bathroom was marked with the name of a person no longer in the home. A person we spoke with told us the sling in their room was for a hoist but they used the 'stand aid'. This is a piece of equipment that can be used to support people to stand and is not a hoist. On speaking with staff we could not determine who had responsibility to make sure each person had their own slings for use with a hoist.

We found one person had been identified to need a bed extension and bumper due to their height to allow them to sleep comfortably. We saw the person had been waiting for six

months and this was still not in place.  Staff told us this had been re-ordered on 10 June 2014.

We saw there was a supply of pads that had been delivered to the home but these had not been made available to people in their bedrooms.  Senior staff told it was their responsibility to make them available in people's rooms but they had not had time to do this.

**Staffing** ✖ Action needed

**There should be enough members of staff to keep people safe and meet their health and welfare needs**

## Our judgement

The provider was not meeting this standard.

There were insufficient staffing arrangements and numbers of skilled and experienced staff to meet people's needs safely and effectively.

We have judged that this has a major impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

## Reasons for our judgement

At the time of our visit we were told there were 58 people who lived at the home but seven were in hospital. We asked the manager how many staff were planned to be on duty during the day and night. We were told there were four nurses and twelve care assistants for the whole of the home from 8am to 2pm and four nurses and ten care assistants from 2pm to 8pm. At night there was one nurse and three care assistants allocated to each floor.

In addition to this there were dedicated staff to complete laundry, cleaning and catering duties.

We requested a copy of the home's dependency tool to show how they had arrived at the staffing levels for the home. This is a tool used to identify whether people are high, medium or low dependency and identifies how many staff would be needed to support people safely and effectively. We were told there was no dependency tool for Coundon Manor.

We looked at the duty rotas for the home for the period from 2 June 2014 to 16 June 2014. We could not identify from the rotas which unit the staff had been allocated to. This meant we could not tell if there were sufficiently trained Registered General Nurses (RGNs) and Registered Mental Nurses (RMN's) supporting each unit. We also could not check how staff were deployed across the home. We saw the numbers of staff as stated by the manager were on duty. We saw the home was operating with high numbers of both agency staff and some bank staff. This meant people did not always receive care from familiar staff who were fully aware of their needs. On the day of our visit we arrived when the night staff were still on duty. We were told a member of bank nursing staff was in charge of the home. This was not indicated on the duty rota so it was clear who was in charge. On the ground floor dementia unit, there was an agency nurse on duty who had not worked at the home before. Permanent staff told us they felt pressured because they needed to support agency staff. One permanent staff member told us, "My head is so full

of stuff I can't remember everything."

At 07:20am a call bell was ringing on the first floor elderly frail unit because one person required assistance. We did not see a member of staff on this unit until 07:44am when the call bell was answered and the nurse attended to the person. This meant the person received delayed support.

We spoke with the nurse in charge of the elderly frail unit. The nurse told us they had 28 people on the unit. They stated there were 23 people that required two staff members to assist them with transferring and hoisting. We were told that five people required assistance with their meals. Staff told us it was difficult on occasions to find another staff member to assist people with their personal care. We observed one staff member looked for assistance. This staff member told us, "I am looking for someone to help me to assist someone off the toilet." They told us it was difficult to find staff to help because staff were already supporting other people.

We spoke with a member of care staff. They told us, "Truthfully I have worked with four care assistants." This suggested the home had not been maintaining the planned staffing levels consistently.

We spoke with day and night nurses as well as care staff about the staffing levels at the home. They told us, "We need more help." "We have staffing issues here." "We rely on agency staff so have no continuity." "Because of low staff, some people go without a bath or shower, we just don't have time." "Sometimes we have two staff on each floor. Promised relatives and staff a ratio of four residents to one staff member, but sometimes its ten to one. We try as much as we can with personal care even if short staffed. Nurses make a list and we try to keep to it. If someone needs a shower more, another person would be put back." One staff member told us, "This is desperate and this is how it is." They also told us: "It's more like an institution. I am losing my passion."

We asked staff whether the staffing levels impacted on the care they provided to people. Staff told us they were unable to spend quality time with people or spend time with people at meal times. Staff told us, "You feed people more as a task and sometimes more than one person." "Some people may go without a bath or shower because we do not have enough time, especially if we have to bath someone who needs it." One staff member told us they were still completing personal care for people at 11.30am on the day of our inspection. In view of comments made by staff, we could not be confident there were sufficient staffing arrangements in place to meet the needs of the people.

On one unit we were told three people had a bath or shower every day. The nurse was not able to confirm if anyone had actually had a bath or shower that day. We were told each person had a bath or shower once a week and a bed bath/wash every day. We could not identify there was a sufficient system in place for monitoring this or to check the frequencies of baths and showers were in accordance with people's wishes.

We looked at the training matrix for staff who worked at Coundon Manor. We saw training was provided for staff on an ongoing basis. Where training was due, the training matrix indicated this so that the manager could arrange it. Training included health and safety, moving and handling people, safe handling of medicines and safeguarding vulnerable adults.

We found a number of people who lived at the home had developed pressure sores which

had resulted in safeguarding referrals being made. We spoke with the nurses about this. We established there was a lack of knowledge and skills to deal with skin integrity problems. They had not undertaken any recent wound management training. A staff member we spoke with told us, "Pressure sores may have been avoided if they had more staff." They told us the dependency of people on the unit they were working on had decreased recently so the staffing was "better." They also told us they felt most of the problems came with staffing levels and stated, "For example, we may not be able to turn people two hourly." A second member of staff told us, "Staffing levels have been quite poor in the past. When staffing levels are low I do question if care is compromised. For example, pressure area management, whether turns are being completed on time."

The new manager told us wound management training had been identified as a training need for staff and this was planned.

One member of staff we spoke with told us they would like more "hands on" training. They stated that some staff had started work without their manual handling training. This can place people at risk when being supported.

**Assessing and monitoring the quality of service provision** ✖ Action needed

**The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

## Our judgement

The provider was not meeting this standard.

Systems were not in place to regularly assess risks to people and monitor the quality of care and services that people received.

We have judged that this has a major impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

## Reasons for our judgement

We did not see there were systems in place to enable the home to obtain the views of people who used the service. We were told the last quality survey was undertaken in 2012.

We found during our inspection there were various areas where improvements were needed to ensure people received the quality of care and services they would expect.

During our walk around the home we found some people did not have access to their call bell. This meant people would not have been able to summon staff assistance if they needed help. Whilst some of these people may not have been able to use one, we found people who could. This included one person who was in bed and their call bell was on the floor out of reach. We gave the person their call bell. We asked if staff came when they used the bell. They told us, "Yes, after a long while. They can't hear." They told us, "It could be an hour." The same person asked us to pass them their television remote control which was also out of reach. They wanted to watch the television.

People we spoke with about the home were generally positive in their comments. One person told us, "Staff are always friendly, it's nice and clean, the food's alright and it's nice." A relative we spoke with about the staff told us, "They're always joking and having cuddles, they do contact us if something's wrong."

We spoke with one person who told us they did not know what was for lunch. A care staff member told us there was a printed menu in each dining room for people to look at. We saw this showed the menu for the day before. This meant information was not readily available to people on the menu choices.

We could not see that people were always involved in making decisions about their care and support. For example, we saw a 'consent to photography form' had been signed and dated by a person's relative as opposed to the person themselves. Records indicated the

person had capacity to consent to decisions. It was therefore not clear why a relative had been asked to do this.

One person told us if they wanted to make a complaint they would. They told us they would, "Find the manager." This demonstrated they felt at ease to raise a concern should they need to.

We asked to see the complaints log for the home. This contained copies of three letters to complainants dated on the day of our inspection to acknowledge receipt of complaints received. We saw one person had been invited to attend a meeting to discuss their complaint further with no other options for an investigation to be progressed. Some complainants are not always able to attend meetings or may not wish to.

There was no clear complaints record to show the date complaints had been received and dates of any actions taken in response. We asked to see details of all complaints received. We were provided with details of three. We saw one person had complained their relative had lost weight. Their complaint had not been acknowledged within the timescale of the organisations policy and procedure. We were told this was usually within two days of receiving a complaint. We established it was ten days. We were aware there had been other complaints received by the home but these had not been recorded in the complaints file we were given. We could not be confident complaints were being effectively managed and responded to.

We found the home was operating with high numbers of agency staff. We found agency staff did not always know key information about the home. On the day of our visit an agency night staff member did not know the door code to the first floor. They told us they had not been up to the first floor during the night. They also did not know the code to the cleaning cupboard. They told us they had needed access to this to clean a person's room during the night due to the person shredding their incontinence pad over the floor. During the morning a glass vase was broken, the staff member tried to find someone who knew the door code to let them in. It then became evident other staff did not know it either.

We saw accidents and incident records had been completed which detailed any injuries people had sustained. We saw accidents happened at varying times during the day and night. At the time of our visit there had been no analysis of the accidents and incidents to identify any trends or concerns. This is important to swiftly identify any actions needed to reduce these from reoccurring. We saw for example there was one incident where staff had removed a sling from underneath a person in a wheelchair. The wheelchair overbalanced and tipped backwards. There were no action points noted to show this had been investigated and to show moving and handling techniques had been reviewed to help prevent this from happening again.

At the time of our visit a new management team was in place, some of whom, had only been in post for three weeks and others a few days. The management team had recognised that basic care had not been managed properly including wound management. They had taken action to start to address this by booking staff training and holding a meeting with all staff. They had identified interim actions to address issues with staffing. This included setting up an agreement with a care agency for staff to be block booked to allow for improved staff consistency across the home. They had attempted to make sure staffing numbers did not fall below the numbers they expected although there had been challenges with staff sickness.

The management team told us new equipment had been ordered for the home. We saw a range of audit processes had been prepared for implementation to help identify where there may be the need for improvements across the home. This included audits in relation to medication management, the environment, kitchen management, infection control, home equipment including pressure relieving equipment and a monthly manager's audit.

Following our inspection, the provider told us, "We are fully aware that leadership at the home has not been of an acceptable standard. We have addressed this by bringing in highly experienced Home and Deputy Managers (the deputy is experienced in Amore Care Policy & Procedures) and clinical leads. There are 59 residents on site (five in hospital) 23 upstairs and 31 downstairs and we have rostered a minimum of four nurses and 12 care staff each morning; four nurses and ten care staff each afternoon and two nurses and six care staff overnight. In addition the deputy manager will remain full time supernumerary."

Staff we spoke with told us they felt encouraged by the new management team and felt the new manager had been supportive in understanding their issues of concern.

**This section is primarily information for the provider**

## Action we have told the provider to take

### Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activities | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Care and welfare of people who use services** |
| | **How the regulation was not being met:**<br><br>People did not always receive care and treatment in accordance with their needs to maintain their health and welfare. Regulation 9 (1) |
| Regulated activities | Regulation |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Management of medicines** |
| | **How the regulation was not being met:**<br><br>People were not protected against the risks associated with medicines because the provider was not ensuring that appropriate arrangements were in place to manage medicines. |

**This section is primarily information for the provider**

| Regulated activities | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Safety, availability and suitability of equipment** |
| | **How the regulation was not being met:**<br><br>Systems were not in place to ensure there was sufficient equipment consistently available in good working order which staff could use to support people appropriately. Regulation 16 (1) (2) |
| Regulated activities | Regulation |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Staffing** |
| | **How the regulation was not being met:**<br><br>There were insufficient staffing arrangements and numbers of skilled and experienced staff to meet people's needs safely and effectively. |
| Regulated activities | Regulation |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening | **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Assessing and monitoring the quality of service provision** |
| | **How the regulation was not being met:**<br><br>Systems were not in place to regularly assess risks to people |

**This section is primarily information for the provider**

| | |
|---|---|
| procedures<br><br>Treatment of disease, disorder or injury | and monitor the quality of care and services that people received. Regulation 10 (1) (a) (b) (2) (b) (i) (c) (i) (d) (e) |

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 23 July 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

## About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

| | |
|---|---|
| ✓ **Met this standard** | This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made. |
| ✖ **Action needed** | This means that the standard was not being met in that the provider was non-compliant with the regulation.<br>We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete. |
| ✖ **Enforcement action taken** | If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people. |

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact -** people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact -** people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact -** people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

## Glossary of terms we use in this report

### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

| |
|---|
| Respecting and involving people who use services - Outcome 1 (Regulation 17) |
| Consent to care and treatment - Outcome 2 (Regulation 18) |
| Care and welfare of people who use services - Outcome 4 (Regulation 9) |
| Meeting Nutritional Needs - Outcome 5 (Regulation 14) |
| Cooperating with other providers - Outcome 6 (Regulation 24) |
| Safeguarding people who use services from abuse - Outcome 7 (Regulation 11) |
| Cleanliness and infection control - Outcome 8 (Regulation 12) |
| Management of medicines - Outcome 9 (Regulation 13) |
| Safety and suitability of premises - Outcome 10 (Regulation 15) |
| Safety, availability and suitability of equipment - Outcome 11 (Regulation 16) |
| Requirements relating to workers - Outcome 12 (Regulation 21) |
| Staffing - Outcome 13 (Regulation 22) |
| Supporting Staff - Outcome 14 (Regulation 23) |
| Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10) |
| Complaints - Outcome 17 (Regulation 19) |
| Records - Outcome 21 (Regulation 20) |

### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

## Glossary of terms we use in this report (continued)

**(Registered) Provider**

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

**Regulations**

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

**Responsive inspection**

This is carried out at any time in relation to identified concerns.

**Routine inspection**

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

**Themed inspection**

This is targeted to look at specific standards, sectors or types of care.

## Contact us

| | |
|---|---|
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