Amore Elderly Care Limited

Coundon Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place in the evening of Tuesday 14 March 2017, and during the day on Wednesday 15 March 2017. The inspection was unannounced on Tuesday 14 March, and we told the provider we would be back to complete the inspection on 15 March 2017. The service was rated as 'requires improvement' at the last inspection, but there were no breaches of the Regulations.

Coundon Manor is a nursing home which provides both permanent accommodation, and respite or temporary accommodation to people who require nursing care and dementia care. The maximum number of people the home can accommodate is 74. At the time of our visit, 69 people were using the service.

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.'

There were not enough staff on the dementia unit to keep people safe and to respond to people's dementia care needs and the risks associated with these needs. There were enough staff on the first floor to keep people safe. Since our last inspection the service continued to have a high turnover of staff which meant there had been a high level of agency staff used, but this had reduced significantly in the last two months.

The provider understood their legal responsibilities to apply for deprivation of liberty safeguards for people who did not have capacity to make decisions and whose liberty was being restricted. Not all care staff had received training in the Mental Capacity Act or understood the importance of gaining people's consent before care tasks were undertaken. It was not always clear why decisions had been taken in a person's best interest when they lacked capacity.

Staff mostly had a caring approach towards people, but they did not have time to provide care centred on the needs of the person. Care was task focused on both floors of the home. People's dignity and privacy was mostly respected.

The cook provided different meal options for people, but some people were not offered a choice and staff did not know how to support people who lived with dementia to make food choices. We were concerned that staff on both floors did not have the time to support and encourage people to eat their lunch and tea time meals.

Friends and relatives were welcomed to visit the home at any time during the day or evening, and could spend as long as they wished with the person they visited.

People's medicines were mostly administered safely and their healthcare needs were met in a timely way.

Most staff had undertaken training to provide them with the knowledge and skills to work with people safely, and staff received management support with individual meetings and team meetings.

The registered manager responded to complaints in line with the organisation's complaints' policy and procedure. Most relatives and staff felt the registered manager listened and responded to their concerns.

The provider undertook their own quality checks of the service, and the registered manager undertook monthly audits to ensure people's health and safety. The checks were rigorous in relation to health and safety issues and in ensuring records were maintained. They were less focused on the 'lived' experience of people who lived in the home.

The registered manager had notified us of incidents that affected the safety of people who lived at Coundon Manor. They had also fulfilled their legal responsibilities by completing and returning the Provider Information Return to the Care Quality Commission when requested.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were enough staff on the first floor 'elderly frail unit' to keep people safe, but not on the ground floor 'specialist dementia unit' to ensure risks were managed to protect people. Staff recruitment procedures reduced the risks of the service employing unsuitable staff. Medicines were mostly managed safely.

Is the service effective?

Requires Improvement

The service was mostly effective.

Staff had received training to support people's health and safety, but many working on the specialised dementia unit had not received or completed specialised dementia care training. Meal choices were available but not all people received these. Staff did not always have time to encourage people to eat their meals. Deprivation of Liberty Safeguards were in place for those who required them, however the principles of the Mental Capacity Act were not always followed. People's healthcare needs were met in a timely way.

Is the service caring?

Requires Improvement

The service was mostly caring.

Staff were kind and caring to people but care was mostly linked to the provision of personal care and not in meeting people's social and emotional needs. People's right to a private space was not always upheld, but their right to privacy during personal care was. People were mostly treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who lived in the dementia unit did not have their needs responded to as well as those on the first floor. Staff supported people with their personal hygiene on a daily basis, but showers or baths were provided when staff had time to support people

with these, not when people wanted them. Two activity co-ordinators arranged activities to support people's individual interests and to provide group activities. The registered manager investigated complaints appropriately, and there were systems to get feedback from people and relatives of those who used the service.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

The provider had not supported the home by ensuring there were enough staff. Staff who worked on the dementia unit were not always suitably trained, and the home did not always provide person-centred care. The provider had not ensured people who required extra support to eat always received this. The registered manager and provider had undertaken other checks in the home to identify whether there were areas which required improvement and to make sure these had improved.

Coundon Manor Care Home

Detailed findings

Background to this inspection

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

The inspection took place on Tuesday 14 March between 4pm and 9pm and Wednesday 15 March 2017 between 10am and 5pm and was unannounced on the first day of our visit. The provider was informed we would be returning to the home on the second day of our visit.

The inspection team consisted of two inspectors and an expert-by-experience on Tuesday 14 March, and three inspectors on Wednesday 15 March. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert on this inspection had experience of supporting a family member who lived with dementia.

Before 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 improvements they plan to make.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority or clinical commissioning group (CCG).

Many of the people who lived in the dementia unit were not able to tell us in detail about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

During our visit we spoke with 16 people who used the service, eight relatives and friends of people who used the service, a visiting dietician and doctor. We spoke with 24 staff, including nursing and care staff, housekeeping staff, an activity co-ordinator and the maintenance worker. We also spoke with the deputy manager, the registered manager and the visiting operations director. We looked at six care plans, recruitment files, management audits and health and safety checks, nine medicine records, supplementary records, the complaints file, staff rota and staff dependency tool.

Requires Improvement

Is the service safe?

Our findings

At our last visit in February 2016, the service required improvements to ensure people were safe. This was because there was a large number of new staff at the home who had not received their training and had not got to know people who lived at the home. This meant people's needs were not always met.

Since the last inspection, the registered manager had contacted the CQC on a few occasions to inform us they continued to experience challenges in recruiting and retaining both nursing and care staff. Because of this, they had to use more agency staff than they would have wished, some of whom they had not asked to return to the home because of poor practice issues. The registered manager told us that 46 staff had left the home since our last inspection and 41 staff were new to the service since we last visited.

This meant the service continued to have a large number of new staff at the home. As well as this, some key staff, were temporarily absent from the home and this also impacted on the continuity of staff provision and care. The registered manager told us they had started to see an improvement in staff retention. They explained they had reduced their agency hours from over 200 hours a week before December 2016 to 36 hours during the week of our inspection visit.

The registered manager told us they had changed the way they had recruited staff to include a personality test. They hoped this meant new staff would be much more suited to the role of a care worker and less likely to leave. The changes to recruitment practice had only been in place for a few months but the registered manager told us early indications were the changes were working.

Prior to our visit we had received a significantly higher number of safeguarding notifications from the service than we would normally expect from a service of this size, and the number of notifications had increased over the last few months. The notifications informed us that the behaviours of some people who lived at the home had put other people at risk. These were in the ground floor dementia unit.

Some of the notifications we had received referred to people going into the rooms of others, and this had put other people at risk with their behaviours. The response from the service to this risk was to put people on 'half hourly observations'. Staff confirmed that they 'did try' to complete these observations but due to staffing levels this was not always possible. We asked if this was a risk. One said, "Yes, we try and manage it but 30 minute observations are not realistic."

The provider information return told us, 'We provide enough staff in the home to care for the residents who live here. We measure dependency levels on a regular basis to check we have enough staff to meet people's needs.' We checked whether there was enough staff to care for people who lived in the first floor 'elderly frail unit' and the ground floor 'dementia unit'.

We looked at the staff dependency tool used by the provider. This is a staffing tool which assesses the dependency levels of people who live at the home, and how many staff are needed dependent on dependency levels to keep people safe. The registered manager told us they had more staff on duty than the

tool determined they needed and this was because they took into account the lay out of the building. The building design meant it was not always easy to see or attend to people quickly.

We were concerned the dependency tool was weighted more towards physical care needs as opposed to the social and emotional care needs of people who lived with dementia. We discussed this with the registered manager who told us most of the people on the dementia unit scored as having a high level of dependency and was staffed accordingly.

During our visit, we spent a lot of time observing staff interaction with people on both floors, and talking with people and the staff who supported them. This was to see whether the number of staff supported the needs of people who lived at the home. From our observations and discussions we found people were safe on the first floor, but we had concerns about the safety of people who lived on the ground floor dementia unit.

We noticed safety gates had been put on the doors of a number of bedrooms on the ground floor dementia unit. This was because some of the people who lived on this floor had lost the capacity to understand that people's bedrooms were their own private space, and upset others by walking into their rooms. One relative told us, "The gate is at mum's doorway to stop the [people] coming in and having them stand over her bed. It frightens her."

During the late afternoon and evening, we saw people walking up and down the corridors and into rooms where there were no safety gates. Staff did not guide people out of the bedrooms unless the person in their room displayed displeasure or agitation with this. A member of staff told us, "We have a lot of males that wander. If they are not distressing people we let them go in (to people's rooms)." This meant staff did not respect people's right to private space. However, we saw staff did not have time to monitor the actions of people.

We found there was not enough staff available to be able to observe what people were doing. For example, late afternoon on the first day of our visit, we found a person shuffling on their knees in their room to reach their en-suite bathroom. It took two minutes for us to find a member of staff to support them, and because the person needed two staff, more time was then taken finding another member of staff to assist the person to go to the toilet.

At 8.15pm on the first day of our visit we saw a person walk down the corridor, and try to go into another person's room. In response to this, the person was punched by the person who lived in the room. At this time of the evening there were three night staff and one nurse on duty to support 34 people who lived in the dementia unit. We called a member of staff to support the person, however if we had not seen this occur, it was not likely that staff would have known this had happened. This was because all staff were busy providing personal care to people and were not available to support people who were moving around the unit.

During the second day of our visit, just after lunch, one person on the dementia floor hit three members of staff within a two minute period. These staff knew the person well and used appropriate distraction techniques, but it took them time to diffuse the situation. This meant that half the staff working in the unit, were attending to one person. As well as people not being safe, there was also an issue around staff safety.

The registered manager told us they were trying to move people to different bedrooms on the ground floor to make it safer for people. They told us when people had been initially assessed to see if they were suitable to live at Coundon Manor, there were no concerns about whether their behaviours might challenge others

who lived with them. They told us the behaviours had changed once they moved into the home.

Night staff told us it was very busy working at nights. At night each floor had three care workers and one nurse to provide support for people. They told us with so many people who required two members of staff to support them with personal care, and with the night time hourly checks for bedrails (which most people had in use), four hourly positional checks (for people who could not re-position themselves in bed and needed assistance to turn), and incontinence pad checks it could be challenging to meet people's needs in a timely way. Staff told us there had recently been an increase in the paperwork they had to complete and this was adding to what they thought was a high degree of pressure.

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

We checked whether people had easy access to call bells as this was a concern at our previous visit. Most people who could use one had their call bell in reach. However at approximately 6pm we walked passed a person who was in distress. They told us they had seen the dentist that day. Their chest and shirt was saturated from excess saliva and they wanted to change these and their trousers. The call bell was attached to the sensor mat and was unavailable to them.

We heard call bells going off on numerous occasions and found these were responded to in a timely way. However, a relative on the first floor told us their relation had recently been kept waiting for 30 minutes one week-end for staff to attend the call. Staff told us that sometimes it sounded like the call bell was ringing for a long period of time but these were activated by people who were setting off the sensor mats and staff did not feel they needed to rush to attend to these as they knew people's needs. We were concerned this might mean people's safety may be compromised as sensor mats should be used to alert staff of a person being at potential risk.

We checked the provider's recruitment practices. The registered manager checked staff were of good character before they started working at the home. We looked at the recruitment records of three staff, and spoke with staff about their recruitment experience. The registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. New staff confirmed they were not able to work at the home until the recruitment checks had been completed.

We checked the administration of medicines to see if they were managed safely and whether people received the medicines prescribed to them. One person told us, "I get my tablets when I need them. We sort of get them on time." Another, whose medicines needed to be given at a specific time, told us, "Most of the time I get my medicines (at the right time)." We saw the nursing staff administer medicines to people and at the same time undertake checks of the blood/sugar levels of people who lived with diabetes prior to their meal time. We saw the nurse administer medicines safely and accurately recorded the administration in the medicine record sheets.

We checked nine medicine administration records and found all but one were correct. One showed a zero balance of stock but appeared to have a staff member's signature to say the medicine was administered. New stock had been ordered. A relative told us their relation had been prescribed antihistamines by the GP on 10 March, but they still had not arrived by the time they were talking to us. The registered manager informed us that urgent prescriptions were delivered on the same day. The antihistamines prescribed were considered a non-urgent prescription and would not have been processed until the next working day which was after the week-end.

We looked at medicines prescribed on an 'as required' basis. We saw medicine plans which explained why the person might need this medicine, and staff recorded on the MAR when and why it had been given. However, the information was limited. For example one person was given an 'as required' medicine for 'pain'. There was nothing to indicate where the person was experiencing pain or why. The nurses agreed it would be a good idea to include this.

We looked at checks to ensure the premises and equipment were being maintained and health and safety checks were in place. The provider's audits clearly documented the checks carried out on the premises and equipment and any actions required arising from the audits. For example, a health and safety audit had found a number of 'breaches'. On the day of our inspection the provider's health and safety manager was at the home supporting the home to be compliant with the breaches they had found.

Requires Improvement

Is the service effective?

Our findings

We checked whether people received the food and drink they needed to keep them well. There were mixed views from people about the food provided with some really enjoying it and others not finding it good. For example, one relative said, "My wife never turns anything down, she eats well," and a person who lived at the home told us, "I am a bit fussy. I do like it but it is the same thing over and over." Whereas another relative said, "Mum doesn't like the food, I wouldn't fancy it." And a person who had to eat a pureed diet told us about a recent meal, saying "The mashed potato was full of salt, the spicy mince only had salt and pepper in it and I had to use the baked bean juice to make it moist."

During our visits we saw there was a choice of meals but this was not always offered to people, particularly those who received their meals in bed or who could not easily communicate a choice. For example, we saw a member of staff put food on a plate and cover it to take to a person's room. We then asked the person if they had been offered a choice before their meal was plated up for them. They replied, "No."

On the first day of our visit, the tea time choice had been changed but neither the staff or people knew what it had been changed to. The menu told us sausage rolls were available to people. We didn't see sausage rolls, instead we saw another pastry but we could not determine what the filling was. We were told the delivery van had not supplied the home with the sausage rolls but the change to the menu had not been communicated to staff or people.

We also saw a lot of food not being eaten by people. Staff did not have the time to encourage people to eat and quickly removed people's plates when it looked like they had finished. A relative told us they visited three times a week and chose to assist their relative to eat during their visits. They said, "I know [person] eats at least three good meals a week this way. There is not enough staff to help [person] eat." They went on to explain they were worried the person did not get enough to eat or drink when they did not visit because staff did not have time to assist them.

Another relative had just supported their relation to have two full beakers of juice because they were thirsty. They commented, "There is just not enough staff to make sure [person] has enough to drink when they need one."

People were not always provided effective support with their eating and drinking. For example, one person received a meal without checking with them if it was their choice. On their plate were large chunks of chicken and the person started to use their hands to rip the chicken up. A relative alerted staff to this, who then cut the person's meat up into smaller chunks. As the person started to eat, the food spilled off their plate and went on the table. Again, a relative had to alert staff and ask for a plate guard to ensure the food stayed on the plate. Staff had forgotten to clip the plate guard on.

We looked at the additional food and fluid charts used for people who needed extra support and monitoring with their diet and hydration. We found some of these had not been completed correctly to ensure it was clear how much people had eaten and drank.

The home had two 'hostesses' to support care staff provide meals and drinks to people from 9am to 3pm. Care staff numbers reduced at 2pm. This meant during the afternoon and evening there were less staff available to support people with their drinks and evening meal.
This was a breach of Regulation 14 (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit, we attended a meeting between the dietician for the home, the registered manager and deputy manager. At our last visit the dietician was concerned that foods such as snacks between meals and after 6pm were not being recorded. They felt these records would assist them in making sure people were receiving the extra foods needed to meet their dietary needs. During this visit the dietician was very pleased with the progress the service had made, but felt minor improvements were required in making sure the weight loss scores given were consistent and correct, and in making sure care plans clearly identified action staff needed to take to support a person in their dietary needs.

At our last inspection visit staff training required improvement, as did staffs' understanding of the Mental Capacity Act. During this visit we again found improvements were required in these areas.

At our last visit not all staff had received training the provider considered essential to meet people's health and social care needs. This was because there was a large amount of new staff at the home and the registered manager did not have enough staff to cover the shifts whilst staff were receiving the training they required. During this visit we found most of the training which was considered essential had been provided to new staff.

However training to support staff to more fully understand how to work with people who lived with dementia, and the Mental Capacity Act had not been available to all staff, or had not enabled staff to develop the required understanding to support them in their work.

The provider's dementia training is called 'Creative Minds.' Some nursing and care staff told us they had either not received, or not completed this training. Some said they had started the training but because of shift patterns they were unable to complete the remainder of the course, having to work their shifts instead. Or, the training was cancelled. Staff also received 'mandatory' on-line dementia training. Whilst some staff found this useful, others did not because they could not ask questions or discuss the issues. The on-line training was basic dementia care training.

A person who lived with Parkinson's disease also told us staff were not very knowledgeable about their condition and said, "You think they would get staff together and explain."

Staff who worked on the dementia unit, whilst caring to people, did not always demonstrate good practice when providing dementia care. For example, we saw staff ask people who lived with dementia what they would like to eat. Because of their dementia, some people did not know what staff meant when they spoke to them about the choices of food. After several attempts to find out a person's choices, we asked a staff member if they ever offered visual choices of plated food to help remind people what the meals were. They replied, "That's a good idea." Two meal options were then plated up and were show to people to support them to choose their meal. A relative commented, "They don't usually do that."

We looked at how new staff were supported in their first few days and weeks working at the home. Staff told us they worked alongside more experienced members of staff for their first few shifts before they worked on their own. They undertook some of the expected training and they found out about the service's policies and procedures.

We checked whether new staff had undertaken the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. The registered manager told us three staff had completed the certificate and 21 were currently undertaking it. They also told us staff had undertaken national vocational qualification to levels two and three.

The registered manager acknowledged there had been issues with staff training, and had been relying on external providers to supply some of this. They were in the process of identifying and training their own staff to become in-house trainers. We spoke with one member of staff who had just taken on this role and had started to identify which staff required further training and 'observed practice'.

We asked staff what other support as well as training they received from the provider. They told us they received individual meetings (supervision) with their senior approximately once every two months. We had mixed opinions from staff as to whether these meetings were helpful. Some felt they were useful in discussing any concerns they had, and others thought that concerns raised were not addressed.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At our last inspection visit, we found staff did not fully understand the MCA. During this visit we again found there was confusion about what the Act meant and how to put it into practice. For example, not all best interest decisions were decision specific and did not demonstrate they were the least restrictive option. All people in the home had bed rails. Where people did not have capacity to give consent to bedrails, there was no information as to why this was in their best interest, and if there was a less restrictive alternative.

Staff understood they could not make a person do anything against their will. They told us if a person refused care, they would respect this and try to provide care at a different time or with a different member of staff if the person was more amenable to this. A relative told us how staff would gently coax their relation to have personal care to good effect and as a result the person's hygiene had improved. They commented, "She wasn't bothering with her own personal care and now because they have worked with her she looks cleaner."

However, during our visit we saw instances where staff did not get the person's consent before they undertook other care tasks. For example, we saw a few staff put clothes protectors on people without asking the person's consent. We also saw in one person's file, photos of their skin had been taken to send to their GP for review. Whilst this helped the GP in their treatment of the person, the photos had been taken before a best interest decision had been made to determine whether the photos could be taken without the person's consent as they did not have the capacity to agree to this.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the registered manager had applied for DoLS for those people who lacked capacity and whose liberty had been restricted. We spoke with a visiting DoLS assessor. They told us they had visited the home on several occasions to complete DoLS assessments and felt the nursing staff knew what they were doing to protect people's rights.

People's day to day health needs were met by the nursing staff on duty. Where people required further health care support, staff referred them to this support in a timely way. The GP surgery used by the home had an 'advanced nurse practitioner' who attend the home twice a week to assess people's medical needs. They assessed whether the person needed referral to the GP or another specialist if required. On the day of our visit one person had seen a dentist. Another told us they had been to see an optician, and a nurse who dealt specifically with their medical condition had been to see them. We saw by looking at people's records other practitioners such as a chiropodist, and social workers had also visited people at the home.

Requires Improvement

Is the service caring?

Our findings

People who lived at the home were mostly very positive about the care provided, but some told us there were some staff they did not feel were as good. For example, one person told us, "See these girls here, they are fantastic. These girls do try their best. There are some really nice ones." We asked if they were all nice, and were told, "No I would be telling lies if I said yes, there are more good than bad." Other people told us, "The girls (care workers) work long hours. The regular ones are spot on," and, "The carers are lovely, they help me so much. They seem to know what I need."

The provider information return told us that 'staffing levels are continually evaluated in relation to dependency levels to ensure staff have time to talk and establish a sociable and clinical relationship with residents'. We experienced staff trying their best to be caring, but they could not provide care centred on the needs of the individual person because they did not have time to engage with people other than when supporting people with personal care tasks.

For example, one of our inspection team sat in a lounge on the first floor for 45 minutes and there were no staff present. The only time staff came into the lounge was to take a person out of the lounge to provide them with personal care. We informed the registered manager of this. They told us they felt staff had not acted naturally on the days of our visit. They said staff normally sat in the lounge with people every day before lunch and in the afternoons. Staff views were different to this.

Staff we spoke with during our inspection, particularly those in the dementia unit told us they had little time to engage meaningfully with people. One staff member summed up what most of the staff we spoke with told us. They said, "We come in and do personal care, then it's straight to breakfast, then personal care. Then we do lunch then personal care; then tea and personal care before the person goes to bed." Another said, "With the staffing levels we have, we just about meet people's basic needs." We found this to be the case.

One staff member commented, "I would like to spend more time but we can only talk to people when giving care or helping them to eat." Another told us, "A lot of people are lonely and they want people to sit and have conversations. Some need re-assurance. Some days we have enough time, other days we don't have the time to sit down and chat."

At our last visit we found staff were considerate to people's needs and made it clear they mattered to them. At this visit, this mostly continued to be the case. For example, a member of staff noticed a person shouting 'help me.' They went over to the person and stroked their hand which reduced their anxiety. Another example was when a person became anxious when using a hoist. Staff reassured the person throughout the hoisting process by telling them what they were doing. A third example was when we saw a staff member walked alongside a person with a walker patiently and at the person's own pace. The person wanted to eat their meal with their friend. They did not find the friend in the dining room and so the staff member patiently walked with the person back to their own room.

However, we saw some less positive practice. On the first floor we saw staff ignored a person sat a dining table where they were serving meals. Staff continually reached across the person, without speaking to them, to pick up plates so they could plate up the meals for the other people in the dining room and those who were having meals in their bedroom. When staff had finished serving up the meals for other people, they proceeded to support the person to eat their meal. They continued to stand whilst supporting the person. We asked if they would like a chair to sit on, but they declined this offer. This meant they did not accord the person with dignity and respect by sitting with them whilst they helped them eat.

Another time, again on the first floor, we saw one staff member supporting two people to eat at the same time. They moved from one chair when feeding one person to another table to put a spoonful of food in another person's mouth. Again this did not show dignity or respect for either person they were supporting.

At tea time on the dementia unit, one hour after the tea had been served we saw one person still sat at dining table alone in a dining room. They had pushed their unfinished pudding away, and had not drunk the tea beside them. They were repeatedly folding their napkin at the table. No staff were available to encourage the person to eat or drink or to check they were feeling okay.

Staff were aware to promote privacy and dignity when providing personal care to people. Staff knew to make sure doors and curtains were shut so people were not exposed. They knew also to minimize people's embarrassment by covering parts of the body when providing body washes and showers. A relative told us, "I think staff are caring. They shut the curtains when giving a wash and always cover her private areas when washing her."

We saw staff being respectful of people's dignity by asking people in hushed tones if they wanted support with personal care. However, in the dementia unit, people's rights to privacy in their bedrooms, was not respected because staff did not have the time to ensure people's personal space was not encroached by people they did not welcome into their rooms.

Whilst we saw some practice which meant people were not always treated with respect, this was not because staff did not care for people. Throughout our time at the home we found staff wanting to provide good care and look after people well. Staff told us they 'adored' some of the people who lived at Coundon Manor, and treated people the way they would like their own family to be treated. Not all staff had been trained to understand people's needs, particularly with dementia.

At our last visit, the manager had recently re-introduced a 'resident of the day' system which meant one day each month the person and/or their representative met with designated staff at the home who checked whether they were receiving care in the way they wanted. This included housekeeping staff, the chef, nursing and care staff, but did not include the activities worker to see whether their social care needs were being catered for. The registered manager told us they would consider including the activities worker in the monthly review.

Relatives told us they were involved in people's reviews. One relative told us, "Yes I have just had a review, they are going to try and get a chair for her (a specialist chair to enable the person to sit safely when out of bed)." The registered manager informed us they undertook two reviews a year where relatives were invited to discuss people's needs.

Friends and relatives were made welcome at the home and there was no restriction on visiting times or the length of time they could stay with the person. Relatives supported their loved ones by helping them to eat and drink.

Requires Improvement

Is the service responsive?

Our findings

At our last visit we found improvements were required in the home's responsiveness with people. This was because daily charts indicated that people were not receiving a wash or assistance with mouth care before going to bed at night. There were also concerns that people were not getting their showers at the time they wanted them. During this visit we found that people were receiving a wash and assistance with mouth care at night, but we still found showers were not provided to people when they wanted them.

Staff told us they ensured people had showers during the week, but this was usually when they had the time to do them. One member of staff said, "Every week we have a shower book so when we come on duty in the morning we check who has had a shower in the week. Yesterday nobody had a shower so we decided to do two today…by the end of the week all residents are showered." A person told us they were normally told when they were going to have a bath. They told us they had enough baths to feel clean, but got quite upset when discussing this, telling us that sometimes they felt staff were 'rough' when they washed them and hurt their legs. We told the registered manager about this person's experience, who said they would discuss this with staff.

Both staff and relatives told us there was a problem with the supply of continence products. We were told that towards the end of the month people could be using continence pads which were the wrong size for them because all the correct sized pads had been used before the next delivery was due. This meant some people experienced discomfort because they were 'soaked' when staff went to change their pads because the pads did not meet their needs.

The registered manager told us normally each person was assessed individually and prescribed pads for a period of eight weeks. They said a number of staff had mixed up some of the day and night pads using a large supply of night pads during the day. This meant some people used pads which were not sufficient for night use and made them soaking wet. The registered manager told us for that period, they bought a supply of pads to support people's care until the next delivery and the issue had now been resolved. They also told us staff had received training from the continence team to help them understand the different products.

The specialist dementia unit had admitted some people whose behaviours became more challenging to others after admission. The registered manager had booked staff on to a course to support them in working with people whose behaviours challenged others. Whilst this responded to the person's behaviour it did not respond to reasons behind the behaviour.

The provider's website told the public that Coundon Manor was a specialist dementia home, and a brochure was attached which informed people what they should expect from the organisation's dementia care units. This said, "Understanding the reasons behind responses is important in providing high quality care. Changes in response are often an expression of communication and not intentional." We looked at the care plan of a person who was known to become anxious and agitated. There was nothing to indicate staff had looked at what trends or patterns there were in the person's behaviour to try to understand the reasons behind the behaviour and to make sure they received the care they needed.

We found one person had recently had their eyes tested and had been provided with new glasses and a new prescription. The person had very poor eye sight and relied on their glasses to give them some vision. We saw the person without them on both the evening and day of our visit. When we asked staff where they were, we were told they had been lost but they did not know when they had been lost or how long the person had been without them. There had been no action taken to look at replacing them. We were later informed by the registered manager the glasses were found in the person's pocket.

Another person on the dementia floor asked three different staff on three separate occasions for their glasses. All staff told the person they would get their glasses for them because they could not walk. After three hours, the person was still without their glasses. We asked a member of staff if the person wore glasses. They said, "Oh yes, she does but every time we give them to her she takes them off or hides them down the side of the chair." Staff did not ensure people who lived with dementia were not further confused by not being able to see properly.

This was a breach of Regulation 9,(Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider information return told us the registered manager planned to develop the dementia care unit to be more person centred and to develop themed areas that stimulated memories for people with dementia. It acknowledged that, 'this would reduce boredom and frustration'. The registered manager was also planning to work on the outdoor space so people could get more enjoyment from the garden areas. We found this was needed because there was very little to engage people with dementia. We noticed memory boxes had been placed on the walls, but few had pictures or artefacts to stimulate memory.

The service employed two activity co-ordinators. One of the activity workers was on leave and so we could not see how well people's interests and hobbies were usually supported. The worker who was available to talk to us felt there was sufficient time when both were working to meet people's needs. They told us when people moved into the home they met with them to find out what their hobbies were so they could tailor activities to meet their needs. They said, "One person loves horse racing and Jockeys. I found a horse racing book and I read the book to the person which they enjoyed."

Upcoming activities on display included a singer and a Mother Goose pantomime, as well as a trip to the Coventry Motor Museum. A person who lived on the first floor told us, "There are plenty of activities on different days". Another told us they sometimes went to a nearby garden centre. However, a relative told us, "There isn't much variety of activities here.

We looked at how complaints were managed. The registered manager investigated all complaints they were made aware of, whether they were formal written complaints, or verbal concerns relayed from people or their relatives to staff. The complaints were investigated in line with the provider's complaints procedure and the outcome of the complaint conveyed in writing to the person who raised the concern. A person who lived at the home had complained some people who used bedrooms near them were noisy. The registered manager had relocated these people to reduce the noise levels.

The registered manager also held relatives meetings every two to three months. One relative told us, "Family meetings are for us relatives to give our point of view. I always try to come but they are very poorly attended." Another said, "I have been to a few meetings…I asked if [relation] could have a table with wheels on, and they gave us one." We looked at the minutes of these meetings. We saw a guest speaker from the DoLS team had attended the relatives' meeting in October to inform relatives of the MCA and DoLS. The meeting in January 2017 discussed the feedback of the recent relative/resident survey. This showed, whilst

there was a low take-up for the survey, of those who completed it, the results were generally positive. There was a visitor's suggestion book in the entrance to the home, but this was empty of suggestions.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had sent us notifications to inform us of incidents that had affected people who lived at the home. This is a legal requirement. Notifications provide the Care Quality Commission with information about how the home is managing incidents and accidents. The notifications from Coundon Manor alerted us that a higher than expected number of safeguarding referrals had been made to the local authority. These informed us that some people who lived on the dementia unit were putting other people who lived on the unit at risk because of their actions and behaviours. Whilst the registered manager had taken some actions to reduce the risks, people were still not safe because there were not enough staff on the unit to keep people safe.

Staff working on the dementia unit had not received the specialised dementia training necessary to provide a specialised dementia care service. The provider's website informs people that 'Our experienced and trained staff are committed to providing the highest quality of care and have a detailed understanding of the unique nature of dementia. Our Registered Nurses and Carers have additional specialised training in dementia care and in each region we have a Dementia Coach who supports our national Dementia Lead with the implementation of our Dementia Strategy'. Many of the staff we spoke with who supported people on the dementia unit had only completed the basic dementia training and not the specialised Creative Minds training provided by the organisation. The training audit undertaken by the organisation focused on the training considered essential to meet people's health and safety needs, but did not check whether staff were suitably trained to understand and work with dementia care.

At a previous inspection visit, we had raised concerns that people were not getting support with eating and drinking. The home put measures in place to improve this, however at this inspection we were concerned that once again people were not getting the support they needed to eat their meals because staff did not have the time to provide people who needed it, the encouragement to eat. At our last inspection we rated the home as 'Requires Improvements'. We saw similar themes and concerns during this inspection but the impact on people who lived at the home was greater because their needs were more complex.

At the time of our previous visit, the provider was regularly visiting the home to speak with people, staff and their relatives, and listening to, and responding to their views about the service and the care provided. We found the operations director for the region continued to visit the home on a monthly basis to check on the quality of care provided. The operations director's reports were comprehensive in looking at issues such as health and safety, staff recruitment, records and documentation, and medicines. However, we were concerned that the focus of their reports was on documentation. Whilst there was some discussions with staff, people and relatives, these were minimal in comparison.

The registered manager or delegated member of staff completed a range of checks to ensure people's safety. These included accident and incident audits, care plan audits and infection control audits. However, there was not a focus on the lived experience of people who lived at the home. For example, a 'dining experience audit' checked whether the dining room was presentable and clean, but did not include whether people using the dining room had a good dining experience in terms of being provided with staff support

and encouragement.

Most staff we spoke with were positive about the management of the home. Positive comments included, "Since the manager has come there have been positive changes. You can go to her or the deputy and they will sort things out." "The managers are okay, they have their work cut out as it's such a big home." And, "I get on well with the managers, we have a good relationship." However, some staff felt management did not listen to them. They felt they had told management about their concerns relating to the level of staffing and these had not been heard. Some staff also felt the management was more likely to criticise than praise and said they would like to hear more about what they did well, and not just what they were doing wrongly.

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

Although we had concerns that the provider and registered manager were not meeting the complex needs of some people who lived at the home, we saw the registered manager had worked with staff to improve care practice within the home. Team meetings were held with the varying staff groups where practice issues were discussed. We looked at the minutes of meetings held with kitchen, nursing and care staff. The registered manager had identified and discussed areas of practice in the home which needed improving and had reminded staff of their expectations. We also found they had identified an area in the home where staff were performing less well. To improve staff performance they had moved staff around to get a better skill and experience mix.

People and their relatives were also mostly positive about the home's leadership. One relative told us the registered manager had made a positive difference and the ambiance of the home had improved over the last couple of months. A person on the first floor also told us, "The manager really cares about people, she had made changes and is trying to get more staff." A relative told us they did not know much about the manager because they usually visited in the evening and at week-ends and so had not had much opportunity to get to know them.

The provider had a legal requirement to inform the public of the home's inspection rating. The provider's website informed the public Coundon Manor had been rated as overall 'requires improvement', and a poster with their inspection ratings was displayed in the reception area of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person-centred care where their needs and personal preferences were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not receiving the appropriate support to eat and drink. This included not receiving encouragement as well as physical support when they needed it.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not mitigate the risks relating to the health, safety and welfare of people. They did not improve the quality of the experience of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed on the dementia unit to manage people's risks and respond to their care needs. Not all staff were suitably trained to provide 'specialist dementia care.'