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: 10 December 2012

Date of Publication: January 2013

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Priory Elderly Care Limited
Registered Manager	Mrs. Wendy Collington
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 Diagnostic and screening procedures Treatment of disease, disorder or injury

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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 10 December 2012, 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 and talked with staff.

What people told us and what we found

On the day of our visit we spoke with eight people living in the home, three relatives and a visiting GP. We also spent a period of time observing those people unable to speak with us. This was so we could determine what it was like for people living in the home.

We found that some people were involved in making decisions about their care to enable them to maintain some independence. We identified improvements were needed in the delivery and maintenance of care to keep people safe. Care records were not always up-to-date to make sure staff managed risks and delivered care that met people's needs. Improvements were also needed to address people's privacy and dignity.

Whilst we had concerns about care, people were positive in their comments about the home. They told us: "All very good." "It's smashing they are all friendly people." They were also positive about the staff. Comments included: "Staff are ever so nice." "They have been very kind to me."

We observed that staff were rushed in their work and task orientated. We observed incidents of concern involving people living in the home which went un-noticed by staff. This was because staff were busy.

Quality monitoring was not being carried out on a regular basis to ensure people were receiving the quality of care and services they expected.

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 19 January 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's privacy and dignity was not always being maintained.

We have judged that this has a minor 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 saw that people had access to some information about the home to help them make a decision on whether to live there. This included a leaflet about the service. The provider may wish to note that the information leaflet did not contain accurate information.

We spoke with three relatives about the home. They felt staff communicated with them when needed. They told us they were able to visit any time and were made to feel welcome. We spoke with eight people living in the home. Some felt they were involved in their care and others said they were not. Comments included: "On the whole there is a good atmosphere here." "It's a funny old place here with different types of people. "

People and relatives told us they were involved in the reviews of care where changes and developments were discussed. One relative told us they had signed their relative's care record to show they had agreed to the care planned. Care files seen contained information that relatives had provided on people's life history. This information contained details such as people's past hobbies and likes and dislikes to help staff deliver person centred care. Care files also contained signed consent forms such forms to consent to photographs of them being used on their file.

The service had maintained some community links such as those with the local churches. A catholic priest was visiting the home on a weekly basis to give people Holy Communion. There was also one person in the home visiting the church each week with their family.

During our visit one person within the dementia unit told us they liked dancing. We saw care staff encouraging this person to dance by playing music in the lounge. Staff told us people were encouraged to be involved in their care; to be independent and to choose their care options. We saw records showing staff had attended training in the Mental Capacity Act. This was so they had an awareness of how to support people who may not be able to make decisions for themselves.

We found that some people's privacy and dignity was not always being maintained. We observed several incidents where this was demonstrated. Some examples are given below.

We observed one person with a catheter bag. They did not have the appropriate stand to hold the bag in place. This meant the catheter bag lay on the floor by their feet. We spoke with a relative of another person living at the home. They told us they had made a request for a stand as their relative had a catheter bag also left on the floor beside them.

We saw a person walking around the home holding the top of their trousers so they did not fall down. They appeared to be too big. The bottoms of their trousers were frayed and the hem was flapping on the floor presenting a trip hazard. When this was raised with staff they rolled the trouser bottoms up. Later in the day the hem dropped down again. This person was also seen with an incontinence pad falling out of the bottom of their trouser leg.

We observed one person with faeces under their nails. This could have presented a risk to the person's health and also did not promote their dignity.

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.

Care and treatment was not being planned and delivered in a way that ensured people's safety and welfare.

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

On the day of our visit we spoke with eight people living in the home, three relatives and a visiting GP. We also spent a period of time observing those people in the home that were not able to speak with us. This was so we could determine what it was like for them living there.

All the people we spoke with were positive about the home including the GP. People told us: "All very good." "It's smashing they are all friendly people." "They are very helpful and do what they can for me."

During the morning we saw staff instigating a dancing session in the lounge. Care staff danced with people and some people danced independently. There was laughter and smiles all round and some people hummed or tapped their feet to the music. We also saw staff talking to people who could communicate on a one to one basis about their past lives.

We observed those people with limited abilities to effectively communicate received less staff interaction than those who were able to communicate well. This could lead to some people feeling isolated and less valued.

We asked people about the food. They told us: "Very good. It's nice to get up and get breakfast, dinner and tea all prepared." "I have my meals in the dining room except for tea and sandwiches. It's as good as you can expect for a place catering for a lot of people."

We found care and treatment was not always planned and delivered in a way that protected people's safety and welfare. For example we saw that one person had leg ulcers. There was a leg ulcer care plan in place but this was not up-to-date. It did not state the current condition of the ulcers. It was also not clear about how these should be managed. Staff told us this person's legs should be elevated for at least two hours a day. This was not detailed in a care plan. We observed the person throughout the day and did not see their legs elevated. We saw a record stating they were sleeping in a chair at night as opposed to their bed. We did not see a risk assessment to show whether any risks

associated with this had been assessed and were being managed.

During our visit we saw some people in the dementia unit with behaviours that challenged staff. We saw one person needed to be supported with personal care as they had soiled themselves. They were refusing to be assisted by staff despite their repeated attempts. This resulted in the person walking around in stained clothing and soiling chairs. We looked at the care records for this person as well as a second person who had behaviours that challenged staff. This was to see how staff were managing these behaviours.

Records stated that both people were reluctant to receive personal care. There were no indications of people's normal patterns of behaviour. There was limited information about any difficulties this presented to the person or staff. This meant we could not determine what people's behaviours were like over a period of time. We also could not see how staff should have delivered support to ensure a consistent approach to these behaviours.

There were risk assessments in place to manage individual risks such as the risk of falls and nutritional deficiency. We found information in the risk assessments was not always being acted upon. For example, one person required a soft diet. We saw they were given food that had not been specifically prepared for them and they could not eat it. The person told us they were hungry. We alerted staff to this.

We saw records showing some people had been assessed as requiring bedrails to manage their risk of falling out of bed. We did not see completed bedrail risk assessments showing how the risks related to bedrail use were being managed to keep people safe.

We saw monitoring sheets on care plans for staff to record when people had fallen. We found these did not contain accurate information. This meant we could not be confident the risks associated with falls were being managed to keep people safe.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

Systems and processes in place to identify abuse and protect people from the risk of abuse were not always being followed.

We have judged that this has a minor 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

The home had a policy and procedure on safeguarding people from abuse. Staff were aware of their responsibilities in relation to this and of how to report any safeguarding concerns.

Training records confirmed staff had received training in protecting vulnerable adults in 2011 and 2012. Staff provided appropriate responses when we asked them how they would deal with an incident of actual or suspected abuse. They gave examples of the different types of abuse and the signs that could indicate a person had been abused. Comments made by staff included: "I would report abuse right away." "I wouldn't hesitate to report abuse of any kind."

People spoken with about concerns or complaints all said they would speak to staff if they were not happy about something. This demonstrated that people had confidence in the staff to manage their concerns. A visitor told us: "If there were any serous matters, I would speak with the manager to get it sorted." We saw there had been three complaints received by the home since 2011. Each complaint had been addressed by the manager and records showed they had been responded to in a timely manner.

On reviewing the home's incident logs we found records of three recent incidents of concern that should have been reported to the Local Authority safeguarding team. The home had determined the outcome of incidents without following the appropriate or formal processes required. Additionally these incidents had not been reported to us. This meant we could not be confident risks to people were being appropriately managed to keep people safe.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

Staffing arrangements were not sufficient to enable staff to deliver the care and treatment people required safely and 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

On the day of our inspection we spoke with eight people who used the service and two visitors. They were complimentary of the staff. They told us: "Staff are ever so nice." "They have been very kind to me."

The deputy manager told us the home was not operating to full capacity and there was currently no registered manager in post. We were told staffing levels reflected the number of people in the home which was 35. There were 17 people on the dementia unit and 18 on the frail elderly nursing unit. The home planned to have two nurses and three care staff for the dementia unit and one or two nurses and three or four care staff on the frail elderly nursing unit.

We observed staff throughout the day during their interactions with people and relatives. They supported people in a caring and professional manner. Staff we spoke with were knowledgeable about the people they were caring for.

On the morning of the inspection the home was short of one member of staff due to a staff member phoning in sick. A replacement member of staff arrived at 11.00am to provide support. Throughout the day staff appeared pressured in their work having little or no time to stop and talk with people about topics of interest to them. The exception was a short period of time on the dementia unit during the morning when care staff danced and spoke with people in the lounge.

Staff told us it was not always possible to spend time with people to talk and listen to their stories because of the staffing levels. They described an approach to their work that was driven by tasks and not by the needs of each individual.

We asked people if they felt there were always staff around to support them. They told us: "Yes, they do have a crisis now and again." "I think there is, we used to see more of them." "I don't see much of them."

We observed several incidents of concern during the day where staff were not around to witness them or did not notice them due to being busy with other people. This included one person in the dementia lounge attempting to pull the lights off the Christmas tree which nearly toppled over onto them; A person attempting to pick a newspaper up of the floor – there were concerns they could fall over; A person slapping another person across the face because they came too close to them; A person losing their incontinence pad out of their trouser leg leaving this in the middle of the floor presenting a trip hazard to others walking around.

In addition to this we observed the lunchtimes on both floors. We saw a person on the frail elderly unit having a meal delivered to their room. The person did not eat their meal and staff did not question why this may be. We were told there were seven people living in the frail elderly unit that needed support to eat and there were three staff available.

Staff were not able to spend the time they needed with people to assist them to eat. We observed there were more people needing assistance than there were staff to do this.

In the dementia unit dining room we saw uneaten meals and meals going cold. We saw staff standing over people to put the odd mouthful of food into one person's mouth before going to another to do the same. Staff were rushing in and out of the dining room. One person was attempting to get a drink from a fire extinguisher (this contained a protective cover so they were not at risk). One person was moving the food around the plate and putting some of this on the table. Staff observed them doing this but did not offer to help them eat. People were getting frustrated and shouting out. This increased noise levels in the dining room. This clearly impacted on one person who began to hum loudly as if to show their disapproval. Staff told us the person did not like noise.

There were no planned social activities for the people on the day of our visit. People were seen to sit in their bedroom or lounges listening to music and chatting to each other with occasional interaction from staff. The deputy manager told us planned activities did take place. Records in people's files held little information about activities being carried out. It was not clear how much time was spent with people, and whether people gained any enjoyment or benefit from the activity.

Staff told us they had completed induction training when they commenced employment with the home. Some felt this was more effective than others due to their past experiences of working in care. Staff told us they received training appropriate to their job role. This included training such as safeguarding people, infection control, food hygiene and moving and handling. We saw records confirming training undertaken. Staff told us that some training was computer based and they felt this was not always the best approach to meet their training needs. Moving and handling training was being delivered as a practical session.

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.

The provider did not have an effective system in place to regularly assess, manage risks and monitor the quality of service that people were receiving.

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

People and visitors we spoke with about the home were positive in their views. They told us: "I think they do the best they can, it's not an easy job looking after a lot of old folk." "I have a bit of fun here…"

We looked at how the home monitored the quality of the care and services it provided. We found improvements were required across all of the standards we reviewed. This included attention to privacy and dignity, the delivery of care, care plans, risk assessments, staffing, safeguarding people and the quality monitoring process.

Audits had been carried out to monitor the quality of service such as monitoring people's weight, bed rails and dependency. However, these had not all been kept up-to-date to ensure they could be appropriately acted upon.

We asked the deputy manager to provide us with any information to show whether people were happy about their care. The deputy manager was unable to provide this. She told us a recent survey had been conducted and the information had been sent to head office. The outcome of the survey was not available to us on the day of the inspection.

We saw records showing that people and relatives had been invited to attend meetings where could give their views about the service. We could not see evidence that views and suggestions given by people had been acted upon.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: People's privacy and dignity was not always being maintained. Regulation 17 (1) (a)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was not being planned and delivered in a way that ensured people's safety and welfare. Regulation 9 (1) (b)

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: Systems and processes in place to identify abuse and protect people from the risk of abuse were not always being followed. Regulation 11 (1) (a) and (b)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Staffing arrangements were not sufficient to enable staff to deliver the care and treatment people required safely and appropriately. 23 (1)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not have an effective system in place to regularly assess, manage risks and monitor the quality of service that people were receiving. Regulation 10 (1) (a) (b) and 2 (i) (e)

This section is primarily information for the provider

disease, disorder or injury	

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 19 January 2013.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. 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. We monitor the implementation of action plans in these reports and, if necessary, take further action. 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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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