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

Overall summary

This inspection took place on 21 January 2015. It was unannounced.

Coundon Manor Care home is a nursing home which provides nursing care to a maximum of 74 people. The home operates on two floors. On the day of our visit, 73 people lived at the home.

The registered manager identified in this report is no longer the manager of the home. 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. The registered manager has left the service and a new manager has applied to be registered with the CQC.

The manager had staffed the home in line with the provider's staffing tool. However, a high number of new admissions to Coundon Manor , an increase of new staff to the home, some of whom were inexperienced in care work, and un-planned staff absences, meant that staff were not always responsive to people's needs and safety was sometimes compromised. Staff did not always have time to provide as much care and support as people

Summary of findings

wanted, and the diverse needs of some people had not been fully considered. We saw however that staff treated people with kindness and ensured people's dignity was maintained.

An activity worker was available each day of the week to support people with their activities, hobbies and interests. However they did not have time to provide regular individualised activities to the high number of people living at the home. Care staff did not routinely have time to support people with hobbies or interests.

Staff understood how to protect people from abuse and avoidable harm. People told us they felt safe, although their relatives were concerned about staffing levels.

The provider adhered to the Mental Capacity Act 2005. Staff respected and acted upon people's decisions. Where people did not have capacity to make informed decisions, 'best interest' decisions were taken on the person's behalf.

The provider met the requirements of the Deprivation of Liberty Safeguards (DoLS). The provider had referred people to the local authority for an assessment where potential restrictions on people's liberty had been identified. At the time of our visit, nobody living at Coundon Manor had been assessed as requiring a DoLS.

There were systems in place to ensure the premises and equipment were well maintained.

We saw people received a good choice of food and drink, and people's individual food requirements were well catered for. People's health needs were well met and they were referred to appropriate health care professionals when concerns about their care and well-being were identified.

The manager was working towards an open and transparent leadership culture after a challenging period which left staff feeling demoralised.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

The staff rota reflected the provider's assessment of the staff numbers required, but people did not think there were enough staff on duty, and staff told us that last minute absenteeism had caused problems with providing safe care.

Requires Improvement

Is the service effective?
The service was effective.

The provider understood their responsibilities under the Mental Capacity and Deprivation of Liberty Safeguards. Staff training equipped staff to undertake tasks considered essential for health and safety. People's health care needs were supported and they received a balanced diet which met their individual needs.

Good

Is the service caring?
The service was caring.

Staff were kind and compassionate to people who lived at the home. They understood and supported people's dignity and privacy. The provider was flexible in enabling relatives and friends to visit the home at any time of the day or evening.

Good

Is the service responsive?
The service was not consistently responsive.

People's care was mostly task focused with limited opportunities for people to engage in individualised activities. Complaints were investigated thoroughly.

Requires Improvement

Is the service well-led?
The service was not consistently well-led

Following a challenging period with different managers and styles of management, the new manager was working to improve morale and develop an open culture for staff, relatives and people who lived in the home and improve the quality of the service. A high number of admissions in a short period of time had impacted on the care provided to people.

Requires Improvement

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.

This inspection took place on 21 January 2015 and was unannounced.

Three inspectors conducted the inspection.

We looked at the information received from our 'Share Your Experience' web forms, and notifications received from the provider. These are notifications the provider must send to us which inform of deaths in the home, and incidents that affect people's health, safety and welfare. We also contacted the local authority commissioners to find out their views of the service provided. The commissioners were satisfied with the care provided by the home.

During our inspection we observed how staff interacted with people who lived in the home. We also 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.

We spoke with 10 people who used the service and seven relatives and friends. We also spoke with 17 staff (this included night and day nurses, care workers, domestic, maintenance and kitchen staff), observed the care provided to people and reviewed four care records. We also reviewed records to demonstrate the provider monitored the quality of service (quality assurance audits), medicine management, two staff recruitment records, and complaints, incident and accident records. We also spoke with the manager, and regional manager who attended the inspection.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Coundon Manor, but not all relatives or people were confident there were enough staff to support people's needs. One person told us, "There's not enough staff, I wanted a shave yesterday and was told they were too busy. I asked again today and was told again they were too busy." The person was given a shave that afternoon. Another person told us, they had recently been supported to go to the toilet, and staff told them it would only be two minutes before they came back. The person said it was a lot longer than two minutes and so they tried to get off the toilet themselves and, "Slammed into the door".

A relative described how they delivered some care to their family member to help staff out. They told us, "They (staff) have a lot to do out there. I like to take the pressure off them." A relative told us, "My [relation] gets looked after properly and that's the main thing."

Most staff told us the staffing levels had improved and when the rota was covered, there were sufficient numbers to meet people's needs. They told us the problems occurred when the rota was not covered through last minute staff absenteeism. One staff member told us, "We don't always have the six carers on duty, sometimes it is four carers and too difficult." Another staff member told us, "It doesn't feel that there is enough staff, they always seem to be struggling, especially on the ground floor." Another member of staff told us, "Staff wise we get staff cancelling at the last minute. Sometimes we can get cover, sometimes not." A relative told us, "I've been here late at night, I've seen only two staff for the whole of each floor. There have been many times when there have only been two (staff) upstairs and two downstairs." A member of staff told us that if there were insufficient night staff it could mean some people did not get their continence pads changed.

At our last inspection in September 2014, the manager was working to reduce the high levels of absenteeism at Coundon Manor. The manager told us they had significantly reduced absenteeism levels since then. A member of staff told us, "There was a period where we had a problem with sickness and absence but it has got a lot better. We've had lots of changes since then and it has improved."

On the day of our inspection the rota was covered. One staff member on an 8am to 8pm shift had phoned in sick but this was covered by 9.30am. In the morning we saw staff managed people's needs well. As the day progressed we saw staff became busy and less responsive to individual need. For example, we saw some instances when it took staff five or more minutes to respond to call bells. People also told us staff did not always respond to them quickly.

Lunch time started at 1pm. Those who sat at tables had their meals provided to them within a short period of time. We noticed some people who had their meals in bed had to wait a long time between each course. They received their meals at approximately1.30pm. We heard one person banging their knife and fork for some time. We went to their room at 2.25pm and asked why they were doing this. They told us they had finished their dinner a long time ago and wanted their empty plate removing and their pudding brought to them. We noticed other people were still receiving their meals at this time. We asked the person who was banging their knife and fork why they did not use the call bell to alert staff to their needs, they told us, "Because they don't come."

The provider used a 'staffing tool' which informed the manager of how many staff were required on the rota to meet the needs of people who lived at the home. The number of staff was determined by the level of people's dependency and the lay out of the building. The manager told us the home was meeting the staffing levels identified as necessary to support people safely and they felt this provided sufficient staff to meet people's needs.

We asked how many staff on duty during our inspection had worked three months or less at Coundon Manor. We were told out of the 12 care workers, four were relatively new. All nursing staff had worked at the home for longer than three months. We also found there had been a high number of recent admissions to the home, many of who had complex needs, and been admitted from hospital requiring care in bed. We were concerned that the deployment of staff did not meet the complex needs of people at peak times of the day.

Staff assessed and identified risks people had in relation to their care. For example, the risks of falling, eating, moving, and incontinence had been assessed and care plans put in place to minimise the risks to people. However, one person, prior to their admission to Coundon Manor in December, had been identified by the Speech and Language Team

Requires Improvement

Is the service safe?

(SALT) as requiring a soft food diet. During our inspection we saw the person had eaten toast in the morning, and was eating sausages and onions for lunch. There had been no further SALT assessment to determine whether it was now safe for them to eat a normal diet. The manager informed us they would make an emergency referral to the SALT team and offer the person a soft diet until the re-assessment had been completed. They told us at the time of the assessment the person was eating sandwiches, and notes indicated they had progressed from a soft food diet to a normal diet. They had not been aware at the time of the assessment that the SALT team had been involved, and were unaware that a family member had brought the assessment in for staff's information.

We saw other risk assessments had not been acted on by staff. For example, one person was at risk of falling and had a pressure mat next to their bed to alert staff when they were trying to get up from the bed. We saw this had been ringing for eight minutes before staff came to support them. We also saw staff tried unsuccessfully to move a person with equipment which was not in their moving and handling risk assessment. Staff recognised they were putting the person at risk and stopped the procedure. Staff told us this was not the equipment they would normally use. Once they found the correct equipment, the person was moved successfully. We asked why they had not used the right equipment. The staff member told us they could not find it and felt under pressure to move the person.

Staff confirmed that recruitment practice was safe. They told us references had been requested and they could not start work until all the necessary safety checks, including police record checks had been completed. One member of staff told us, "I had to wait about six weeks before my DBS (Disclosure and Barring Service) checks came through."

Staff understood the importance of safeguarding people who lived at the home. They understood what constituted abusive behaviour and their responsibilities to report this to the manager. The night before we arrived there had been an incident which involved two people who lived at the home. We found staff had managed the incident well to protect the safety of both people. They had also reported it to management and to the appropriate safeguarding authorities.

The provider and manager monitored the number of accidents and incidents in the home. We saw the monitoring report which demonstrated that each incident had been analysed and action taken when necessary. For example, one person had fallen four times in one month. Equipment was put in place to reduce the risks of the person falling and half hourly observations had been put in place. The manager had requested the person be referred to the 'falls clinic' if any further falls took place.

Staff were aware of evacuation procedures but not of the contingency plan if people could not return to the home if evacuated. The manager informed us there was a contingency plan and said they would ensure all staff were made aware of this. Fire safety checks had been carried out to ensure fire alarms and fire equipment was in good order, and most staff had undertaken a fire evacuation. Each person had a personal emergency evacuation plan; however these did not always give enough information to support a member of staff in knowing what assistance each person required in the event of an evacuation. The manager told us they would rectify this.

The premises, and equipment were well maintained with regular checks undertaken to ensure equipment such as hoists, and electrical equipment were safe to use.

We observed medicines were administered safely to people. One person who had a condition which meant they had to receive their medicines at a specific time confirmed to us that staff met this requirement. We saw this was the case when we went to speak with a nurse. They asked us to wait before they spoke with us because they needed to ensure this person had their medicines on time. Another person told us, "I get the tablets I need, I have paracetomol for pain."

Good

Is the service effective?

Our findings

People and their relatives told us staff had knowledge which underpinned the care provided to them or their relations. One relative told us, "They get trained in dementia, they have told me quite a few things [about dementia] I didn't know."

The provider's training programme gave staff with the skills and knowledge to deliver effective care. The provider had an induction training programme (for new staff) and a yearly training programme to support staff in refreshing their knowledge and skills in areas of care considered essential to the health and safety of people. This included areas such as infection control and moving people safely (using equipment such as hoists). Much of the learning was using computer based e-learning programmes. The majority of staff had completed the training expected by the provider and we saw them put their training into practice. For example, we saw staff used personal protective equipment when going to undertake personal care to reduce the risks of infection being transferred from one person to another.

Staff also undertook 'Creative Minds' training. This was a dementia care training package developed by the provider. A staff member who had previously not received training in dementia care spoke positively of the Creative Minds training. They told us, "Now I understand the conditions more. Training has opened my mind to the condition more."

Whilst a lot of the staff had experience as well as knowledge, the manager had recently recruited new staff to work the day and night shifts. Not all of these staff were experienced in care work prior to working at Coundon Manor. The induction period for the home was three 12 hour shifts, during which time the new member of staff 'shadowed' other staff and was not included on the rota. The manager told us they would increase the induction period if they felt a new member of staff was not ready to work on a shift. Staff told us they thought the induction period was sufficient, but one said it would have been helpful if it had lasted longer so they could get to know people's individual needs better. The manager recognised that new staff were not always as effective as experienced staff and reminded staff in a staff meeting that new staff needed support long after their induction days. Staff told us they received support with their work. One relatively new member of staff told us, "I've had loads of help since I've been here. If I am stuck I don't hesitate to ask people."

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

We found staff followed the principles of the Mental Capacity Act 2005 (MCA) and acted in people's best interest. The MCA protects people who lack capacity to make certain decisions because of illness or disability. We saw where people had dementia; assessments had been made to determine what decisions they still might be able to make for themselves. Many people at the home had a 'Do not attempt Cardio-pulmonary Resuscitation' (DNACPR) directive in place. These had been written in conjunction with people or their relatives and the sample we looked at followed current guidance on do not attempt resuscitation orders. The manager told us they were in the process of reviewing these for all people living at Coundon Manor and hoped to have the process completed by early February 2015.

Staff responsible for assessing people's capacity to consent to their care, demonstrated an awareness of the Deprivation of Liberty Safeguards (DoLS). This is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. The manager was aware of the criteria for applying for a DoLS and where potential restrictions on people's liberty had been identified, applications had been submitted to the supervisory body (the local authority) for their consideration, and had new ones ready to send.

We asked people and their relatives what they thought of the food provided. One relative told us, "The food is very good…it is usually hot when it comes." Most people told us they thought the food was good, although one person said, "The food is not great, some days it's alright, the portions could be bigger." We saw breakfast, lunch and dinner being served and that people had choices at each meal time. Food was served hot from the food trolley to people sitting at tables in the dining room. Meals were nicely presented and there were good quantities available. For those having

Good

Is the service effective?

their meals in bed, food was plated and covered to keep their meals hot, it was then taken by staff to people's rooms for them to eat. Drinks were provided to people throughout the day.

The new chef told us there had been a number of recent staff changes in the kitchen. The new team was working to improve the service to people and make sure people had food they liked and in the quantities they wanted. In the last month they had spoken with each person individually to find out their likes and dislikes and to see if there were any changes people wanted to the menu. People who needed a specific diet were provided with it, for example, pureed or cultural diets.

People's day to day health needs were being met. One person told us, "If I need a doctor they would send for one, I have also had the dentist and the optician. I've seen a chiropodist." We saw the GP and other health care professionals attended the home when people required them.

Good

Is the service caring?

Our findings

A person told us, “It’s a very nice home, the staff are very good.” One relative told us, “I think the care is pretty good, far better than I could give – it’s got much better since 12 months ago, the caring has got much better.”

The home was split into two units on each floor. We saw people were able to move around both units as they wished and use any of the lounges or dining areas. One relative told us, “[relation] can walk for miles here.”

When we arrived at 7am we saw most people were still asleep in bed. We saw people gradually got up and had breakfast in their own time. One person was awake and dressed, sitting in their bedroom armchair having a cup of cappuccino. They told us it was their choice they were awake. We saw where people were awake, staff said good morning and had a conversation with them.

We found staff supported people to maintain their dignity. We saw a member of staff, on seeing a person lying in bed whose legs were exposed, go into the bedroom and gently move the person’s quilt so it covered their legs. Later in the day we saw another person had been eating their meal in the communal lounge and got some food down their top. In response to this they had taken their top and under garment off which had left them naked from the waist up. Staff very quickly found a garment to cover the person to maintain their dignity before taking them to put their clothes on properly. However we saw one person had spilt a drink of tea down their top in the morning. In the afternoon they still had the same top on. We also saw a few other people whose clothes had become dirty at meal time and they had not been changed.

Staff told us of other ways they supported people’s privacy and dignity. They said, “I make sure the doors are closed, I make sure residents are happy to go ahead with personal care, I speak to them and make them feel comfortable and I explain what I am doing.” Relatives confirmed when personal care was provided they were asked to leave the room to ensure the person’s privacy. One relative told us, “I don’t have any concerns [relation] is left wet and dirty, they come and check her quite regularly, I have to wait (and leave the room) a minute or two when they do so.”

We saw people treated in a caring and kind way. Staff were friendly, patient and discreet when they provided support to people. One person was observed to get distressed as they were waiting for staff to get equipment to help them move from their chair to a wheelchair. The member of staff who stayed with them saw the person was distressed and started to sing a song to distract the person, which they thought the person would enjoy. The member of staff gently soothed another person who was annoyed with the noise the person was making and explained they could not help it.

People were observed informing staff of their choices. We saw people had a choice of food at meal times, and chose where they wanted to sit during the day. People told us they chose their own clothes, and how they liked to be dressed. They also chose whether to take part in the activities available.

We found advocacy services had been used for people who had no relatives and friends to support them. This meant they had people outside the home who were supporting the person’s best interests.

There were no restrictions in visiting times for friends and relatives to visit the home. One person told us, “Visitors can come at any time during the day.” Some came at mealtimes to support their relation eating. We saw people were visited in the early morning through to the evening. The provider promoted an open culture for people to visit at any time during the day or evening.

Requires Improvement

Is the service responsive?

Our findings

The manager told us they had instigated a 'resident of the day' system at the home to ensure they were responsive to people's changing needs. A member of staff told us, "This is where we have a plan every month and every day we have two residents whose care plans are reviewed. Risk assessments are reviewed and a GP visit arranged or review organised if needed. Time is spent with the resident and a weight analysis is done." However, we saw that one person who had lived at the home since the beginning of December 2014 had not their needs identified during their 'resident of the day' review.

We spoke with this person who was crying out and they told us they were bored and their bed was, "Like being in a coffin." On speaking with us they calmed down and were happy to have a person to talk to. We spoke with the manager who was unaware of this and informed us they would work with the activity co-ordinator to see what they could do to relieve the person's boredom. . Although we saw staff go in to the room on a couple of occasions and were kind and considerate when they spoke with the person, the person's cries were often not responded to because staff were busy doing other things.

One person at the home was unable to speak English. We were told they could understand some English spoken to them and when asked a question, would give staff a sign to indicate their wishes. However this was reactive, and did not empower the person to be more in control of their own care by being able to ask staff questions instead of only being able to answer.

The provider had one activity co-ordinator on duty seven days a week. This meant one person was responsible each day for meeting the interests, activities and hobbies of 74 people, many of whom were not able to engage in group activities. This meant the activity worker had very limited time to spend with people on individual hobbies or interests. On the day of our inspection the activity worker was unable to undertake the arranged morning activities because a person had fallen and they had been asked to support that person. In the afternoon we saw the activity worker engaged four people with a ball throwing activity. One person enjoyed the activity but the others were disinterested, and one made several attempts to get out of their chair and leave the room as they did not enjoy the activity.

Whilst there was limited time for the activity worker to spend with each person, some people told us of the activities they had taken part in and enjoyed. People told us they had been playing dominoes and skittles, and one person told us they were taken to the shops by the activity co-ordinator. We also heard from a member of staff how they had put their 'Creative Minds' training into practice. They told us they were speaking with people at lunchtime and found out that one of the people used to be a music teacher. They then discovered the person could play the piano and so they brought the person to one of the lounges with a piano. They told us, "[person] played the piano for ten minutes. It brought tears to our eyes and it made her day. We didn't know she could play the piano and she remembered it the next day."

We saw the television was on in all communal living areas people were sitting in. People did not appear to be interested in any of the programmes being shown. Whilst we saw music played at lunch time in one communal dining area, we did not see staff make use of music to support people's well-being.

Formal complaints had been addressed according to the provider's complaint's procedure. The manager had taken the complaints seriously and undertaken a thorough investigation of people's concerns.

We observed the staff handover meeting in the morning. Nursing and care staff walked to each person's room where the night shift nurse informed the day staff what each person's needs had been during the night and how this might impact on their care needs during the day. For example, we heard one person had not drunk very much during the evening and night. Day staff were advised to encourage the person to drink more during the day to ensure they received sufficient fluids to stay healthy.

Requires Improvement

Is the service well-led?

Our findings

Since June 2014 the service had gone through a period of management change. A new manager and deputy had started work at Coundon Manor in July 2014, but in November 2014 the deputy manager left the organisation. The manager was not registered with us but we had received their application for registration and this was being processed.

We were told leadership issues since our last inspection had left staff feeling demoralised and unhappy. The manager told us this had led to some staff leaving the organisation. Staff told us morale was now improving. They told us the manager was now more open and accessible to them. One member of staff said, "I feel [the manager] listens. She is getting there. She is easy to approach and talk to." Another member of staff said, "I love working here, it is one of the best homes I've worked in." The manager was open with us about the recent issues which had impacted on staff morale. They told us they had learned from recent experiences and had also put new systems in place to support staff, and to ensure staff felt they would be listened to.

The manager had created a leadership structure which included nurses and care team leaders, to provide all staff with support and guidance. Nurses provided formal supervision for staff, and care team leaders provided spot supervision and guidance to care workers. The manager had arranged regular team meetings to meet and discuss issues with staff, and also instigated 'flash' meetings. These were daily meetings with senior staff to ensure staff were aware of any new or important issues impacting on people who lived at the home.

The manager had arranged meetings for relatives and people to attend so that they could get feedback on the quality of the service. They were also looking at introducing other ways of getting feedback from relatives because attendance at meetings was low. Two relatives told us they had not found the current manager open to criticism in the past. The manager told us they met with individual relatives if they had any concerns about the care being provided to their relation and wanted to forge positive relationships with people.

Most people told us they felt able to share their experiences or raise concerns with staff or management. One person told us, "Before this manager I couldn't talk, with this manager I can talk a bit more now." Another person told us, "I would feel able to speak with staff if I was not happy but the only thing I am not happy about is not being in my own home." A relative who visited the home every day told us," I know who the manager is and would feel able to talk to her if needed to."

The manager was aware of their responsibilities to send us notifications of any incidents that affected the well-being of people who used the service such as safeguarding events or deaths of people who had lived at the home.

In June 2014 there was a breach in the Regulations relating to staffing levels. In September 2014 we judged there to be sufficient staff on the rota to meet people's needs but we had concerns about staff absenteeism. During the same period of time, the local authority also had concerns about staffing and the impact this had people's care. They stopped admissions of people funded by them. They partially lifted this 'placement stop' in September 2014 and it was fully lifted towards the end of November 2014.

Since then, 29 new people had been admitted to the home, 19 of whom were admitted from the end of November 2014. The majority of people admitted had medium or high dependency needs. We were concerned that a high number of admissions had taken place in a short period of time. Staff had limited time to get to know people's needs well before another person was admitted. The manager had also recruited new staff, some who were new to care and needed more time to provide support to people.

The provider informed us they were in the process of improving the activities available to people. They told us in February 2015 they were introducing the "Daily Sparkle", a professionally written reminiscence tool for older people and for people with early stage dementia. They were also providing more support to the activities co-ordinator by introducing monthly conference calls so they could learn about the activities provided in other homes within the company, and looking at introducing music therapy to people.