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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 20 February 2018 and was unannounced.

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

The maximum number of people the home can accommodate is 74. The home is a two storey building. People who lived with dementia were supported on the ground floor, and people who were being re-habilitated from hospital on short term contracts, and those living at the home who had more physical nursing needs were supported on the first floor.

At our last inspection the home was placed into Special Measures. This was because we had rated the key questions of 'safe,' 'responsive' and 'well-led' as inadequate. There were seven breaches of the Regulations. At that time we met with the provider and they provided us with an action plan. This showed what they would do and by when, to improve all areas of the service we had concerns with to at least 'good'. The provider liaised with us by updating the action plan informing us when they had achieved their aims and what outcomes continued to require improvements.

During this visit the provider had made a promising start to improving the service and the home was no longer in breach of the regulations, and no longer in special measures.

Because it had only been four months since our last visit we were aware the provider had not had a significant period of time to move the home forward and sustain improvements made. The provider also shared this view. They had also been made at a period of time when there were less people in the home than usual. This was because the provider had volunteered to stop admitting new people to the home until improvements were made.

At our previous inspection to the service, 70 people lived at Coundon Manor; during this visit 49 people lived at the home. Improvements were required to be sustained over a period of time once further people were admitted to the home.

The registered manager had been the registered manager at Coundon Manor since 2016. 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.

Staffing levels had increased, and there had been a reduction in the high number of agency staff used. New

staff were still becoming familiar with the service and the needs of people who lived at the home. Staff were deployed in specific areas of the home to supervise people in order to promote people's safety and to reduce the risks of people falling.

Care records provided more detail about people, and risks related to people's health and well-being were now being appropriately assessed and acted on. New equipment had been bought to improve the responsiveness of care and to reduce people's risks.

The premises and equipment were clean.

The mealtime experience had improved and people who were at risk of malnutrition or dehydration were getting more support from staff to encourage them to eat and drink healthily. Checks were now being undertaken to identify when people had not eaten or drank so staff could provide further encouragement.

Staff now received better access to training and support. Many staff had completed the provider's accredited dementia training and dignity training, as well as the expected health and safety training. We saw improved responses from staff in relation to people with dementia, and in respecting people's dignity and privacy.

Medicines were mostly managed safely, and the provider had a good understanding of what improvements were required to manage medicines more safely and effectively. Staff recruitment procedures reduced the risk of employing staff unsuitable to work in a care environment.

Staff were seen to be supportive of people, treating them with kindness and respect. People's right to privacy and independence was also supported. Staff appeared happy and enjoyed their work.

Staff felt more supported in their roles. Individual supervision sessions were being planned, and the manager was seen as more accessible. Staff had more opportunities to discuss their work issues with management. Staff felt the provider was now supporting them and the service to improve.

The registered manager and staff understood and complied with the Mental Capacity Act regulations and Deprivation of Liberty safeguards. Staff understood how to protect people from abuse and harm.

People now received showers at times they wanted, and had better continence care and support. People had access to healthcare when it was required. People and relatives now had more opportunities to share their opinions about the care provided by the home. Complaints were being managed according to the provider's policy and procedure.

The provider, registered manager and their management team had worked hard to improve the service. They had made a good start. They needed to ensure the improvements made would be sustained over time and when a higher number of people used the service.

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 mostly safe.

Improvements had been made in the number of staff available to support people on each shift, and there had been a reduction in the number of agency staff used. Improvements had been made in the assessment and implementation of risk reduction strategies to support people's safety. Medicines were mostly managed well. Staff recruitment measures reduced the risk of employing unsuitable staff. Improvements had been made in the cleanliness of the home and the equipment people used.

Is the service effective?

Requires Improvement

The service was mostly effective.

Staff training had improved, and new starters were now receiving an effective induction to the home, although not all new staff were yet sufficiently skilled and experienced. Staff understood the importance of receiving people's consent to care and treatment and worked within the Mental Capacity Act and Deprivation of Liberty regulations. Peoples experience at meal times had improved, as had staff support for people who were at risk of malnourishment or dehydration. People received access to healthcare when necessary.

Is the service caring?

Good

The service was caring.

Staff were kind and caring to people, They had received 'dignity training' and were aware of how to treat people with dignity and respect. Because of an increase in staff numbers they had time to meet people's emotional and social needs and to promote people's independence. Visitors were welcomed in the home.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

People had started to have their needs responded to in a timely way. Care plans had been updated and were now centred on the

needs and preferences of each person. Complaints were now being responded to in line with the provider's policy and procedure. Staff who worked in the dementia unit had, or were scheduled to receive, specialised dementia care training to provide more responsive dementia care.

Is the service well-led?

Requires Improvement

The service was becoming well-led.

Since our last inspection the provider had provided more effective support to the registered manager and staff to make improvements to the service. Quality systems had changed and this had improved the responses of the service in dealing with issues which arose. The improvements were relatively recent, and had not been tested over a longer period of time and with a home at full capacity to ensure sustainability.

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.

Our previous inspection in September and October 2017 placed the home in Special Measures, with seven breaches of the Regulations.

Soon after our previous inspection we met with the provider to discuss our serious concerns about the service. This meeting provided us with sufficient reassurance that improvements would be made.

Prior to our visit we reviewed the action plan and subsequent updates the provider sent to us after our previous inspection. We also reviewed information we received from members of the public and professionals who had been involved with the service. We looked at the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

This inspection took place on 20 February 2018. It was unannounced. The inspection team consisted of three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our visit to the home we spoke with four people and five relatives; we spoke with seven care and nursing staff, one housekeeper, one activities co-ordinator, the deputy manager, the registered manager, the peripatetic manager, the associate director of nursing, the quality improvement lead, the senior quality improvement lead, and the regional director.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. As well as using a SOFI, we also engaged with staff and people throughout our visit to the home.

We reviewed five care plans and 10 medicine administration charts. We reviewed food and fluid charts, and records for repositioning people, mattress checks, three staff recruitment records, quality assurance, health and safety, and complaints records.

We attended a governance meeting at the home in the afternoon. This comprised of the heads of each different section of the home, including maintenance, housekeeping, nursing, kitchen, care staff and management.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we rated this key question as 'inadequate'. This was because staffing levels on both floors of the home were insufficient to meet people's needs; known risks to people's health and well-being were not well-managed; some equipment, furniture and areas of the home were not clean; and medicines were not always managed safely. During this inspection visit we found improvements had been made, although further improvements were still required. People told us they now felt safe at the home, and their visiting relations also thought people were safe.

At our last inspection we found the provider continued to breach Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014; staffing. After our inspection visits the provider sent us an 'action plan' which informed us of immediate increases in staffing levels during the day and night time shifts. It also provided us with actions they were going to take in the longer term to ensure the right number of staff were available to meet people's levels of dependency and need; and actions to support the home in the recruitment and retention of staff. The provider also voluntarily agreed to stop admitting new people to the home until they could be assured that people were safe.

As part of this visit, we checked whether the actions the provider had taken had improved the safety of people who lived at the home. The provider had been in contact with us regularly since our inspection visit and had sent us updates of how they were progressing with their action plan. In October 2017 when we last visited the home, they were using between 250-300 hours of agency support each week, whereas at the time of this visit they had reduced the level of agency support to less than 50 hours a week (this did not include the one to one support provided). Where agency nurses were required, the provider had 'block booked' the nurses for longer periods of time to promote continuity of care.

During our visit we saw sufficient staff on duty to meet people's needs. Staff we spoke with told us they were happy with the improvement in staffing levels. Comments included, "After this happened (our last inspection) we had a lot more staff and more time to spend with residents. The amount of staff to residents is good so we have more time with them now which makes things a lot better."

Whilst we saw enough staff on duty, people we spoke with told us they still felt there were not enough staff available to meet their needs. They told us, "There are not enough staff." One added," They have no time for us. They are all stressed." Relatives said," They still need more staff." And, "There is a high turnover of staff. They use a lot of bank staff, so we don't really know them."

New staff had recently been recruited to the home. Many were still undergoing a probation period and were receiving the appropriate training to support them with their work. This meant that shifts were not always staffed with care workers and nurses who had a lot of knowledge of people's individual needs, and who had the relevant experience to provide care without support of other staff.

Staff acknowledged there continued to be times when there were not as many staff as there should be, but this was usually if staff could not make their shift because they were unwell. One told us, "The managers will

now phone an agency and get someone in. They will try and get them in within the hour." One staff member said, "Weekends can be challenging but that might be because staff don't come in." Another said, "We have had a lot less agency in the last few months. We have had a lot of new staff start which has made things better." A member of the clinical staff told us, "Staffing levels are alright. I think they are managing quite well and I can see team work. They report if they have any concerns and they are helping each other."

Staff told us there was always a member of staff in the lounge on the ground floor (in the dementia unit), because people who lived with dementia were at risk of harm through changes in their perceptions and abilities, their own actions, and the actions of others. A member of staff told us, "There are always staff in the lounge downstairs due to people's risk of falling and dementia."

At our last inspection we raised concerns about the staff dependency tool and whether it provided an accurate assessment of people's needs and the level of staff required to meet those needs. The provider had told us they were going to introduce a new dependency tool. This had recently been introduced. With the high level of vacant rooms, we were not able to determine at this inspection whether the new tool would work effectively when the home was full.

This meant the home is no longer in breach of Regulation 18 the Health and Social Care Act but improvements were still required.

At our last inspection visit we found the provider had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014; Safe care and treatment. This was because we had serious concerns about the number of people who had fallen, and the lack of action taken to reduce the risks of people falling again.

Since our last visit the provider referred those who were at risk of falling to the appropriate healthcare professionals to determine future action to prevent or reduce the risks. They had also initiated a monthly falls analysis and a tracker system to make sure that those at risk of falling were identified early and appropriate action taken. For example, one person was on 'one to one' care 24 hours a day because they were at such high risk of falling and often forgot they could not walk independently. The number of people who had fallen had significantly reduced.

At our last inspection visit we had concerns that there was not enough equipment available for staff to move people safely, and this might result in staff undertaking unsafe moving practice with people. At this inspection we found improvements had been made.

There were two hoists provided on each floor and staff confirmed they were readily available. Risks associated with each person's mobility had been re-assessed and risk management plans detailed how they should be moved, the number of staff required to assist the person, and the equipment to be used. Each person who needed it had their own slings (and a spare) that had been assessed as appropriate for their weight and build. This also reduced the risks of cross infection. Each person also had their own slide sheets which were kept in their bedroom. This meant staff had the appropriate equipment readily available to reposition those people cared for in bed without the risk of damaging their skin or injuring them.

Staff spoke positively about how having the right equipment meant they could deliver care safely and in a timely way. One staff member told us, "There is a hoist always available; there are two on each floor. All have their own slings in their room and their own shower slings which is a lot better. We haven't got to go from room to room." Staff also said they would not hesitate to report other staff who did not follow good manual handling practices.

At our last inspection we had concerns that people were not using equipment such as wheelchairs or lounge furniture that best suited their needs. Since then the registered manager had contacted physiotherapy services who visited the home to undertake an assessment. The registered manager was in the process of acting on advice about equipment which needed to be purchased.

Some people at risk of skin damage had pressure relieving mattresses to reduce the risks of further skin damage. It is important mattresses are at the right setting for people's weight to maximise their effectiveness. An incorrect setting could also increase the risks to people's skin. At our last inspection we found some mattresses were not set at the correct setting. At this inspection we saw the provider had introduced a system to ensure people's mattresses were always on the correct setting. There was a photograph on the end of people's beds which gave a visual prompt as to what the correct setting was. Staff checked the setting each time they repositioned people or provided personal care and signed people's daily records to confirm the checks had been completed. We looked at four people's mattresses and found they were all on the correct setting. Staff had completed the records consistently to confirm the checks had been carried out.

Where people had wounds or skin damage there were care plans in place explaining how they should be dressed and cared for. Photographs of wounds and regular evaluations allowed clinical staff to monitor the wound to identify improvements or where further support was needed to promote healing. One person had contracted limbs and needed a pad to be placed between their arm and forearm to relieve pressure. We saw the pad was in place.

People's care plans included assessments of their individual risks and described the equipment needed and actions staff should take to minimise their risks. Care plans looked at, had been reviewed and updated when people's needs and abilities changed.

We checked to see if medicines were managed safely. People and their relations told us medicines were administered to people as prescribed.

Most of the medicine administration records (MAR) had been completed correctly. Some people were given their medicines through a tube directly into their stomach (PEG). There was detailed information about how staff should care for the PEG to prevent the risk of infection. There was a section on the MAR to remind staff that the PEG needed to be rotated and cleaned daily.

The provider used a recognised pain assessment tool to support those people who were unable to vocalise their pain. However one person's plan said they could experience pain but it may go unnoticed as they were not able to verbalise clearly. There was no information about how this person may demonstrate they were in pain.

There were detailed 'as required' medicine plans for most medicines given on an 'as required' basis. One person told us, "The staff ask me if I am in pain." And when asked if they received medication to relieve the pain they told us they received paracetamol 'twice a day'.

However, one person was prescribed an 'as required' medication for agitation. This was administered through a syringe driver. There was no medicine plan to inform staff at what stage of the person's behavioural changes this should be given. This was important as they were also on another medicine via the syringe driver for pain management.

Some people's medicines could not be given until certain health checks had been carried out, for example

checking people's pulse or blood sugars. The checks had been completed. Where people were on a variable dose, staff recorded how many had been given to prevent the risks of the person taking too many in a specified period.

Where people were given their medicines hidden in food or drink, pharmacy advice had been sought about whether medicines were safe to crush into food or drink.

Some people were prescribed topical creams that were applied directly to people's skin by care staff. At our last inspection records did not always demonstrate that people's creams were being applied as directed. We looked at three people's cream charts. There was good information about the cream, how often it should be applied and a body map which detailed exactly where it should be applied. However, we found that staff were often applying more frequently than prescribed. For example, one person's cream was to be applied every 36 hours but on one day, it had been applied three times and on another day, twice. Another person's cream was to be applied alternate days but was being applied every day. The registered manager said they would address this issue.

At our last inspection we found there had been problems with the supply of medicines to the home and this meant sometimes people did not receive their medicines in time to ensure they were administered as prescribed. Since then, the registered manager told us meetings had taken place with the pharmacy and the GP and the majority of the issues had been addressed.

We found that the week prior to our visit, the provider had conducted a medicine audit of the home. This was very thorough and had identified a number of actions and timescales for staff to address the necessary action.

At our last inspection visit we identified many parts of the home and furnishings were not clean. At this visit we found the home was clean, tidy and well maintained. We spoke to a member of housekeeping staff who told us they had received training so they understood their role and responsibilities in relation to infection control and hygiene. They told us each day they 'deep cleaned' one person's room which included mattresses and bed rails/bumpers. They told us they always had enough cleaning equipment to do their job effectively.

Another member of staff told us improvements had been made in the cleanliness of the home. They told us, "We have more cleaning staff and a head cleaner, who wrote the cleaning schedules. We can raise any other cleaning needs or issues at 'flash' meetings. A member of staff told us, "I like to leave their rooms looking just right – no dirty plates and the room should be clean."

The laundry was arranged to support best practice, in line with the Department of Health guidance. Staff told us they used colour coded washing bags to transport washing to the laundry room. A member of staff said, "We put dirty clothes in the blue bag, bed linen in the white bag and soiled lined in the red bag and take it upstairs. We use double bags for soiled washing. We put it into the big bags for the laundry staff."

We saw staff wore personal protective equipment (PPE) when supporting people with personal care. Staff said PPE was readily available and accessible. However, we saw on one occasion a member of staff did not use good infection control practice when taking used continence wear from one person's room. We shared this with a senior member of staff who told us the staff member was new. They said they would take time to remind them about safe infection control practice.

We saw the most recent infection control checks undertaken by the provider. This identified that not all staff

had completed their infection control training and required the staff to complete within a seven day period. The seven day period had lapsed and some had still not completed this training at the time of our inspection.

The provider was no longer in breach of Regulation 12 of the Health and Social Care Act 2008, however further improvements were still required.

People's care plans included their personal evacuation plans for staff support in the event of an emergency. Staff told us they had training in moving and handling, health and safety and fire safety and they felt well prepared to act effectively in an emergency situation. Staff told us, "We have a fire alarm test on Tuesday, to test the alarm and we go to the fire door."

Staff received training in safeguarding and understood the provider's policies for safeguarding and whistleblowing. They told us they had no concerns about how staff supported people, but would share any concerns with a senior or nurse. A person was asked what they would do if they had any worries. They told us, "I would speak with the nurse." Staff said, "Abuse includes not treating people with respect. They need to feel protected by staff," and "I know about the whistleblowing policy and would use it. I would share any concerns." Another said, "I would go through my chain of command and report it, even if it is belittling behaviour. If nothing was done, I would go to head office and report it to someone higher."

The provider's recruitment procedures reduced the risks of employing staff unsuitable to work with people who lived in the home. References and Disclosure and Barring Service (DBS) checks (The DBS checks whether people have a criminal record) were obtained before staff started work. Where there were any gaps in employment or discrepancies in any information, these were followed up to ensure the suitability of staff. At the last inspection the provider had found recruitment and retention of staff had been difficult. The provider informed us they now provided staff with 'exit interviews' when they left employment. This would give staff the opportunity to talk in confidence of any reasons why they left the service. At the time of our visit one member of staff had used this process.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated this key question as 'requires improvement'. We found at this inspection improvements had been made but further improvements were still required.

At our last two inspections the provider has been in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Nutrition and hydration. This was because people at risk of malnutrition and dehydration did not always receive the food and fluids to support them remain healthy. During this visit we found some improvement had been made.

At our last inspection, we found the two tier lunch time where people who had higher support needs for eating and drinking had their meals before those who were more independent, to ensure staff had time to support them; had been abandoned in favour of a return to the meals being served at the same time to all people. This meant those who required more support did not get the support they needed. The provider's action plan post inspection told us they would be re-introducing the two tier system again, and we saw this in place during our visit.

At our last inspection we had concerns that people were not receiving the fluids they needed to keep them healthily hydrated. The provider's action plan stated they were going to implement a fluid intake check and systems to ensure that if not enough fluids had been drank by a person, staff knew and understood the need to try to improve the person's fluid total that day. During this visit we looked to see if people received the fluids necessary to keep them healthy.

We saw people in bed had drinks on their bed tables that were in easy reach. We saw one member of staff supported a person to drink. They did not rush the person and followed the person's care plan to ensure they had their drink in a safe way. One person told us staff always made sure they had enough to drink. A staff member explained that where people were at risk of not drinking enough, there was a fluid chart in their room. "We have to monitor everything they have had to drink and if they refuse. We go in every 15 to 30 minutes to make sure they have plenty of fluids. I won't leave until they have finished." Another said they now had more time to ensure people had enough to eat and drink, "It has improved because we have less residents. Staff have more time. If people are on fluid charts we try and go in every half an hour 'small and often'. We have time to do that now which helps."

This system had only been implemented in January 2018 and was still to be fully embedded in staff practice. The provider had recently implemented a system of putting dates on the water jugs to ensure that people receive fresh water each day. This was to be checked as part of a 'Quality Walk Round' by the senior team at the home.

Some people at risk of choking were on 'thickened fluids' (thickened drinks are often used for people with dysphagia, a disorder of swallowing function. The thicker consistency makes it less likely that an individual will choke while they are drinking). Staff knew the people who required thickeners in their drink, and what thickness they needed their fluids to be prepared. Each person had their own thickeners which were for their

use only.

As part of our previous inspection we spoke with the medicine management dietician for the home (this person worked for the commissioners of the service to make sure people who lived at the home received the necessary food and fluids for their well-being). They told us they had concerns that people at risk of malnourishment were not getting the supplements they required. This was because people on the dementia unit at risk of malnourishment were not being monitored appropriately to make sure they received the additional nutrients in the form of snacks and milkshakes the chef had specially prepared.

We contacted the medicine management dietician again as part of this inspection to find out if they thought improvements had been made. They informed us the home had made good progress in how they supported people at risk of malnutrition and the home no longer required their input. They cautioned that it was early days, as the improvements had not been in place long enough to be certain they would be sustained.

People's nutritional risks were assessed and their care plans explained the support they needed to maintain a balanced diet and sufficient nutritional intake. People's care plans included their food likes, dislikes and any allergies or specific dietary needs. A member of staff told us, "We have a list of names and types of diets and allergies in the dining room. The menu covers diabetic needs."

We asked people and their relations what they thought of the meals provided. One said, "I enjoy my food. I feed myself. I never ask for any more food and drink". But another told us the food was 'bland'. One person told us they would like more food than they were given, although another said if they wanted more they felt able to ask for it. We were told there had been recent problems with meals at the week-end when the chef was not at work. The registered manager confirmed that there was no chef on duty on the Sunday and Monday prior to our visit and they had received verbal complaints about the meals provided. They recognised they should have had better contingency plans in place for this eventuality and had discussed this with the regional manager who was at the home during the inspection. We were assured this would be addressed to ensure cover for any future absences.

People had a choice of meals and could eat in the dining room or their own bedroom, according to their preference; their relatives were also welcome to support them at meal times. The menu was displayed in words and pictures to support people's understanding of the options. Tables in the dining room were laid with cloths, cutlery, condiments and flowers, which encouraged people to recognise lunch as a social occasion. There was a calm atmosphere and the meal was not rushed. People who needed assistance to eat were supported by staff sitting next to them, speaking words of encouragement and supporting the person at their own pace.

People were invited to use wipes to clean their hands before the meal and to wear clothes protectors, to keep food from spilling onto their clothes. Staff asked people which meal they would like in words and by showing them both options on separate plates. Staff were attentive to whether people ate well or not. When one person who was not able to express themselves verbally declined to eat, we saw staff offered them the alternative meal, to make sure they had a choice of flavours and textures. For people who needed a soft meal, the meat and vegetables were pureed separately to ensure people were able to savour different flavours.

This meant the provider was no longer in breach of Regulation 14 of the Health and Social Care Act, although improvements made needed to be sustained over time.

We looked at how the provider supported staff in gaining the skills and knowledge necessary to be effective

in their work. Staff told us they had the training they needed to be confident in their practice. New staff undertook the Care Certificate, which included being able to understand and work within the fundamental standards of care as recommended for all health and social care staff.

At our previous inspection, staff told us they had not experienced a good induction to the home. During this inspection visit, new staff told us they worked with experienced staff during their induction period, to make sure they had the confidence and skills to work independently with people. A member of staff told us, "I watched two staff for three days in a row during my induction. I learnt a lot. I know people's needs now." The provider's action plan told us they intended to plan a meaningful induction for all new staff and to ensure a mentor system was implemented and to check that those staff who had missed out on an induction prior to our previous inspection, received one. They hoped this process would be completed by the end of February 2018.

More experienced staff told us, "Training has improved. We have had more training with the home trainer." For example, they told us they had training in falls prevention, dignity in care, equality, diversity and human rights and in 'creative mind thinking' to enable them to support people living with dementia. Another member of staff said, "After our last report a lot more training has been given to people." We were also informed of further planned training which included pressure ulcer awareness training, continence awareness training, hydration and nutrition, basic life support and emergency first aid.

One of the nurses we spoke with said they had support to maintain their clinical skills. They told us "I am happy with the training provided to me." They had training in male and female catheterisation and were due to have syringe driver training in March. The nurse said they were doing the syringe driver changes without training but the registered manager assured us there were always two nurses and one had received the necessary training. The nurse said they were encouraged to gain extra qualifications. For example one nurse had applied for mentor training.

Nursing staff said they did not have formal reflective practice but rather discussed issues regularly on an informal basis. One said, "It is done but not on an official basis. When something happens we sit and discuss it. The nurses always chat with each other and share our experiences and what has gone well and what hasn't." They told us they had supervision and recently had an appraisal. There was a student nurse in the home on the day of our visit gaining experience of a residential nursing placement.

At our previous inspection, many staff had not received supervision for a long period of time to support them in their work. During this visit we found staff had received supervision and further supervision sessions had been scheduled for staff to attend.

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.

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 checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

When the registered manager assessed that a person lacked the capacity to recognise and understand the risks of going out independently, they had applied to the local supervisory board for the authority to restrict people's liberty, in accordance with the Mental Capacity Act 2005 (MCA).

Staff understood the principles of the MCA, in particular that 'capacity should be assumed' and people should be supported to make their own decisions. Staff understood they could only restrict a person's liberty if the decision had been made in their best interests, because they did not have the capacity to understand risks. A member of staff was able to explain, for example, "We only use lap belts (in wheelchairs) if they are authorised, and not all the time, only when moving along the corridor." The member of staff understood that continuously encouraging a person to 'sit down', when they liked to walk about, could be considered as a deprivation of liberty. Throughout our inspection visit we saw staff offered people choices and sought their consent before they supported them.

Where the provider had reason to question a person's capacity to understand information about risks related to their care and support, their care plans included a mental capacity assessment. The result of the assessments we reviewed, explained that staff should make decisions about administering medicines and seeking healthcare advice on the person's behalf, in their best interests, because the person might not recognise signs of ill-health themselves.

Staff supported people to make choices. For example, staff brought one person into the lounge in their wheelchair. They asked the person where in the lounge they would like to sit. Records showed that nurses had sought consent prior to clinical procedures. For example, nurses had recorded one person's consent when their catheter was changed. Records also showed the use of bed rails had been discussed with the person. They had consented to their use because they felt safer with bed rails in place.

Staff respected the decisions people made. One person was waiting for the entertainment to arrive and said they didn't want to wait any longer. They asked to be helped back to their bedroom and staff immediately helped them back. Later, we saw they had changed their mind and staff supported them back to the lounge so they could join in the entertainment.

Records demonstrated that staff respected people's right to decline assistance with personal care but balanced this against the need to maintain people's health and welfare. For example, where people had declined a shower, this was recorded. Staff had offered again later in the day, and often people had accepted the support at that time.

People's care and treatment was delivered in keeping with evidence based guidance. Care plans included risk assessments using recognised risk management tools, in line with NICE (National Institute of Clinical Excellence) guidance. For example, universally accepted assessment tools such as the MUST (Malnutrition Universal Screening Tool) for nutrition, and the 'Waterlow' score for assessing the risks of skin damage were used.

Care staff told us they read people's care plans when they started working with them. Staff told us the care plans were detailed enough to get a good understanding of people's needs, abilities, risks and preferences. Staff were confident the care plans were up to date and always available to refer to when needed.

People's care plans included details about their medical history and their current medical risks and needs, to enable staff to identify any signs of ill health. People were regularly weighed to monitor their health. Records showed people were supported to obtain regular checks with other healthcare professionals, such as chiropodists, dentists and opticians.

When other healthcare professionals visited people and gave advice about how staff should support the person, their advice was recorded in their care plans. Records showed staff followed their advice. People and their relatives were mostly satisfied with access to health care. One person said, "I let the staff sort my appointments out". A relative told us they thought access to healthcare had improved. One person said that their hearing had become more impaired since their health had declined but they had not been referred to audiology services. We discussed this with staff on the day of our visit, and a member of staff faxed a referral through.

The premises had been designed and decorated to support people to move easily from their own bedroom and around the communal areas of the home. There were several rooms and areas where people could sit and rest or watch what was going on around them. We saw people who were able to mobilise independently moved freely between the communal areas and their own bedrooms. In the lounge, staff put different music on throughout the day, to support people to relax or socialise according to their mood. A member of staff told us, "Most people go to the lounge, but some people like to sit outside the nurses' room because it is quieter. They can get agitated by the noise and be restless." We noted a few people still sat in the corridor as opposed to using the second lounge as a quiet space.

The lift and external doors for each unit were number coded, to make sure people who needed support from staff to go outside, could not go out unobserved. Every bedroom had an en-suite toilet and shower, which protected people's privacy and dignity. The communal facilities included a secure garden and a hairdressing salon, which supported people's social needs and wellbeing.

The registered manager informed us they had recently received signage to support those with dementia identify the different rooms in the unit. They said the maintenance worker would be putting these up in the next few days.

Technology was used to support people to stay safe. For example, people who had capacity used use call bells, when they needed support from staff. For people who lacked capacity to call for support, they used sensor mats, which alerted staff if people who were at risk of falls got out of bed unobserved. Technology was also used to support independence. A member of staff told us, "We have Wi-Fi (for people to have access to the internet) and people can have telephones put in their rooms."

Good

Is the service caring?

Our findings

At our last inspection this key question had been rated as 'requires improvement.' This was because some people and relatives expressed concerns about staff attitude towards them. One person told us of staff not respecting their dignity; we saw a member of staff tell a person to 'go in their pad' instead of taking them to the toilet; and some staff did not engage with people they were supporting, and did not respect people's dignity when supporting them to eat. This meant the provider breached Regulation 10 of the health and Social Care Act 2008(regulated activities) 2014; Dignity and respect. During this inspection we found improvement had been made and the rating for the key question was now 'good'.

The provider's action plan told us they were going to make sure staff received 'dignity' training carried out by the provider's 'in-house' trainer. They were also implementing a dining experience 'quality walk around' to ensure staff supported people with their meals in a way which promoted dignity and respect. At the time of our visit not all staff had received this training because the in-house trainer had been off work. However they were back at work and moving forward with ensuring all staff received this.

During this visit people and their relatives provided us with more positive responses about the care provided. These ranged from staff were 'okay' to staff were, "Brilliant". Other comments about staff included, "Caring and professional with a smile". "They do a good job". "12 hours is a long shift. They do well". "The bulk of staff are really good" "I get on well with them". "The staff are lovely, they are very nice."

We saw staff were kind and compassionate towards people. Staff smiled, spoke reassuringly, and supported people at their own pace. For example, we saw a member of staff supported a person to have a drink. They did not rush the person, and wiped their mouth between each sip. The staff member then reached over and held the hand of the person sitting the other side of them. They continued to hold the person's hand and stroke it. The person could not speak but their body movements demonstrated they enjoyed the tactile engagement.

At lunch time one person became agitated with the member of staff who was trying to encourage them to eat. The staff member immediately withdrew and another member of staff took their place. They took time listening to what the person had to say and gave reassurance. The staff member bent down to speak to the person at their level and leaned forward so they could hear what the person was saying. The person was concerned about their handbag and was given reassurance it was by their side.

People and relatives told us they thought staff were kind. One person told us "They show great kindness, and a relative said, "They are treated very well."

Staff told us they enjoyed their work. They told us they supported the same people regularly so they could get to know their individual likes, dislikes and preferences well. A member of staff said, "I love them all. They just like to talk." Another said, "I treat them as if they are my own grandparents." "You work in a home, you care for the people and make sure they have got everything they need." "I love it. It is the first time I have worked somewhere I feel at home."

When we asked a staff member if they would be happy for one of their relatives to be looked after at Coundon Manor, they responded, "Yes I would because they are well looked after and cared for." Another staff member said, 'family and community' were important and went on to explain, "I know when there is somebody on that floor who is unhappy or upset and I will spend time with them."

The clinical lead on the dementia unit told us care staff's understanding of how best to support people living with dementia had improved through better training. They told us, "We had creative mind training. It changed things. Now staff talk more, and explain what they are doing to reduce agitation. They explain better about food choices, getting dressed and supporting people to move. Simple things have improved in communication and understanding."

Records showed that for people who had lacked the capacity to discuss and agree how they were cared for and supported, their relatives and healthcare professionals had agreed how best to support them, in their best interests. We saw people were involved in making day to day decisions about their care and support throughout our inspection visit. A relative told us, "My relation can't make proper choices, but the staff help her with meal choices."

Relatives were invited to share information about their relation's previous lives, work, interests and important relationships. Staff told us people's life histories were explained in their care plans, if they were known, which helped them understand people's motivations and routines. A member of staff told us, "Their history is in their care plans and they talk to us and their families talk to us."

We saw people were supported to maintain their independence and staff only assisted them if they wanted assistance. We heard staff ask a person if they would like to be supported to walk from one room to another, or whether they would prefer to use a wheelchair. The person said they would like to walk and we saw two staff walked, one each side of the person, supporting at the person's pace, to the other room. When one person declined to have lunch at the first sitting, they had changed their mind by the time of the second sitting, and were supported to go to the dining room for their meal. Two people who used a wheelchair told us they could independently go where they wanted. One said, "I please myself where I go, in my wheelchair."

A member of care staff told us, "People can decline care or a shower. [Name] declines to shower, but is happy to have a bed bath." We saw staff respected people's privacy and promoted their dignity. Staff spoke quietly and were discrete in supporting people to use the bathroom. People's bedroom doors were open or closed in accordance with their preferences. Some people had low gates at their bedroom doors, which meant they could see out, but other people could not enter their rooms uninvited or by mistake.

This meant the home was no longer in breach of Regulation 10 of the Health and Social Care Act.

Visitors continued to be welcomed into the home and could stay for as long as they wished to.

During this visit we found the provider had been more caring towards the staff group. They had provided the registered manager and their team more support through increased staffing, training and guidance. This had improved the care provided to people and had given staff more time to be caring and compassionate towards those in their care.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, this key question was rated as 'inadequate.' This was because people did not always have their needs responded to in a timely way. Care was not centred on the needs or preferences of each individual person. Complaints were often not addressed within the timescales determined by the provider. Not all people felt the leadership were responsive and open to listening to their concerns. During this visit we found enough improvements had been made to change the rating to 'requires improvement'.

At our last two inspections the provider breached Regulation 9 of the Health and Social Care Act 2008 (regulated activities) 2014, Personalised care. One of the reasons for the breach of the Regulation was the continence care provided to people. This included the ordering the correct size of continence products for people and ensuring they were provided to the person once ordered. It also included staff changing people's continence wear in a timely way. The provider's action plan informed us they would be reviewing each person's continence care plan to ensure the correct sizes of continence wear were documented, and to ensure sufficient products were ordered each month.
During this visit we were satisfied this issue had been resolved. People we spoke with told us their continence wear was changed frequently. Nobody spoke of having the wrong product to wear. A member of staff told us continence care had improved because, "We have a lot more time now."

At our previous inspection we were concerned that people did not receive showers when they wanted them. The provider's action plan informed us they would establish people's wishes for showers and devise shower schedules to suit people's individual needs. The people and relatives we spoke with were satisfied with the shower arrangements. They told us they received between one and three showers a week and this was what they wanted. Staff told us people had at least two showers a week, and more if they wanted them. One said, "Absolutely. Everyone has two or three showers a week and if they want more they can." We looked at two people's personal care records and saw they had a shower seven times in the last 19 days.

At our last inspection visit we had concerns that some people looked unkempt and had dirty finger nails. During this visit all the people we saw looked clean and well-presented.

Our last two inspections reported on the lack of dementia training for staff who worked in the ground floor dementia unit. This is a specialist dementia unit and during our previous inspections we saw staff engage with people in a way which demonstrated their lack of knowledge and understanding of dementia. The provider's action plan informed us they would ensure that 100% of staff on the dementia care unit would receive the provider's own accredited dementia training called 'Creative Minds'. At the time of this inspection not all staff had received this training. This was because many staff were new to the service, and only a certain amount of staff could attend each training event. The provider expected all staff to have completed this training by the end of March 2018. Whilst this action was not yet complete, we saw a big difference in the way staff responded to people on the unit. They took more time with people and provided care more centred on their individual needs.

Previously we reported that doll therapy had started and then stopped at the home. Dolls are looked after

as 'living beings' by some people with dementia. The doll therapy had been stopped because there were no cots or pushchairs to put the dolls into. The provider had not purchased these despite it being known that people on the unit had benefitted from this. The provider's action plan told us they were going to re-introduce doll therapy into the dementia unit and ensure there was an adequate supply of cots and prams.

During our visit we saw staff supported people with doll therapy. Staff supported this therapy by inviting people to look after the doll, or to 'babysit'. We saw several people took comfort from, and were less agitated, when they were holding, nursing and feeding the doll. The updated action plan informed us they were still looking to see whether there was an adequate number of dolls and equipment. From our observation we saw that more equipment such as pushchairs or prams might be useful.

At our last inspection we were concerned that apart from the times when organised activities were available, there were not enough staff available to respond to people's needs, such as providing emotional support or engagement with people on an individual basis. During this visit we saw staff had time to talk with people and engage with them well.

Previously people or the relatives, who made decisions on behalf of people, did not feel they were fully involved in the reviews of people's care. The provider's action plan informed us they would be introducing a quarterly care plan invitation to relatives as an opportunity to review and have input into the care plans. We found that letters had been sent out and the first set of reviews had been held in January 2018. Relatives confirmed to us they were involved in care reviews. One said, "I am totally involved, and I am happy with it". Another said, "Yes a few times a year. They ask me if the changes in the information are ok." However, the people we spoke with did not feel they had any involvement with this. The provider had also, as part of their actions, re-launched the 'resident of the day' initiative in January 2018. This is where all aspects of the person's care are reviewed once a month. We discussed with the provider how people's views about their care could be included in this monthly review.

At our last inspection we found where people needed to be repositioned in bed to reduce the pressure on their skin; the charts which documented when they were repositioned did not inform staff of the time frame between each change of position. The provider's action plan informed us a schedule of turns would be documented on the front of each person's supplementary record. This had recently been implemented with nursing staff provided with supervision to ensure they were aware of the new procedure and their responsibility to cascade to care staff.

Previously, we found care plans did not always focus on the individualised needs and wants of each person. We found care plans had been updated and provided a more personalised response to people's needs. For example, one person's care plan identified the person had some loss of hearing but declined to wear a hearing aid. The instructions for staff were to, "Speak in basic, clear language and give them plenty of time to express their wishes. Contact should be face to face." When talking with staff, it was clear they followed these guidelines. One staff member told us, "I try and talk to them and do a lot of hand movements to explain to them and then they will nod." Another staff member said, "[Person] is able to lip read. If you get down in front of them and speak slowly they can understand you."

Previously we found some of the care plans were difficult to read because of staff's handwriting. The provider acknowledged that this still continued to be an issue which they were addressing by sourcing IT equipment which would enable staff to type the record.

This meant there was no longer a breach of Regulation 9 of the health and social care Act 2008. Whilst we were satisfied there had been improvements, the improvements needed to be sustained over time.

At our last inspection the provider breached Regulation 16 of the Health and Social Care Regulations 2008 (Regulated Activities) 2014: Complaints. This was because some people and relatives felt the registered manager could be defensive when they complained; and because the provider had taken a long time to investigate and conclude complaints made.

Two of the relatives we spoke with at this visit did not feel their complaints had been managed well (one of the issues raised was prior to our previous inspection visit), however another two were happy with the response of the home when they raised concerns. The three people we spoke with and two other relatives told us they did not have any complaints about their or their relation's care. The provider's relatives survey undertaken in January/February 2018 showed that of the 15 people who responded, 14 said they were 'completely' able to raise concerns, with one saying 'sometimes'. Seven of the 15 said their opinions were 'always' listened to and acted upon, with five saying 'mostly', and three saying 'sometimes'.

The provider had received ten formal complaints since our last inspection visit. We saw these had been fully investigated and in most cases meetings had been held with the complainants to discuss their issues and provide feedback. Complaints were also responded to in writing and provided information about what actions had been taken to ensure any issues did not occur again. The responses also included information about how people could escalate their concerns if they did not feel they had been resolved to their satisfaction. Two of the complaints had initially been raised with the CQC prior to our visit. We had asked the provider to investigate these as part of their complaints procedure.

We also received information of concern related to the care of three people at the home. We asked the provider to undertake an investigation of these concerns. We were satisfied the investigation fully explored the concerns raised.

This meant the provider was no longer in breach of Regulation16 of the Health and Social Care Act.

We looked at how people's interests and hobbies were supported. The provider employed three activities coordinators to support people to socialise and to share in group activities and entertainments. A member of staff told us, "We have skittles, bowling, cards, and dominoes, doll therapy and watch old movies with popcorn and ice cream." During our inspection visit, an external support worker brought their dog into the home, for people to pet. We saw people tapping along to a music session in one lounge, and playing dominoes in another lounge.

We spoke with an activities co-ordinator. They told us activities were planned but they adapted them on a daily basis in relation to how people felt and what they wanted to do. They said, "You have got the entertainment and you have got the social side of people getting together as a group. It is stimulation and giving them something of interest. I don't like to see people just sitting there." They were confident activities had improved but felt even more could be done for people.

People and relatives we spoke with provided us with mixed opinions about the activities on offer. One person told us they had previously enjoyed playing dominoes and joined in with the games of dominoes at the home. Another told us they joined in with some of the activities on offer. One relative said they thought the current range of activities was fine for all the people who lived at the home. Others we spoke with had not been involved and were not interested in the current range of activities. All those we spoke with said they had not had a say in what activities should be on offer.

The activities co-ordinator told us an important aspect of their work was spending time with people on a one to one basis. "If they want to talk, I am here to listen." They said they would like more time to spend with

people individually and were working with a local organisation to arrange volunteers to come in and spend time talking with people. We asked why it was important to have that time with people. They responded, "So they don't get depressed. If they get depressed they may get ill. We want them to feel happy because this is their home. It also helps to build up relationships of trust."

During the morning we saw an activity in the first floor lounge. This was an exercise activity and included strength building as well as movement to promote flexibility in wrists.

People were given more opportunities to go on trips outside the home. The activities person could drive the home's minibus and people had been able to visit West Midlands Safari park, go shopping, the transport museum and to Coombe Abbey. A tea dance was the next planned outing.

We looked at how the provider supported people's end of life care. People's care plans included their future wishes, in the event they became unable to express themselves or state their preferences. The future wishes were related to their religion and beliefs, but did not include details about any individual preference requests at the end of their life.

The nurse explained, "What we need to change here is when a resident is quite stable we are not taking this information. We tend to discuss it with the family when people are deteriorating." The nurse told us they liaised with other healthcare professionals including McMillan nurses to ensure people remained comfortable and pain free. One person had been referred to the Coventry Community Specialist Palliative Care Service.

People's care plans included the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form. This plan provides clinicians with information about whether attempts at resuscitation should be undertaken for the person.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection this key question received a rating of 'inadequate'. This was because the home continued to breach the Regulations from our previous inspection visit in March 2017, and further breaches to the Regulations were found at the September/October visits.

At our last inspection the provider breached regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014; Good governance. One of the reasons for the breach was the provider had not acted to improve staffing levels to support people's health and well-being. At this visit we found staffing levels had increased. At our last two inspections we found staff did not have a good understanding of dementia care, at this visit we found many staff had been provided with the provider's in-house accredited dementia care training, and dignity training, and others were scheduled to participate in the near future. At our last two inspections we found people who were dependent on staff supporting them to eat and drink were not getting adequate support from staff. During this visit we found this had improved.

After our last visit, we met with the senior management team of Priory Adult Care Services. They informed us of the changes which had taken place within the provider group and how they expected the changes would improve the service provided. This included more oversight of the services and governance. They acknowledged because of organisational restructuring, they had not provided the appropriate support for the home but assured us the home would now be given the support it required. Since then we have received regular briefings from the provider about the changes made and any challenges they have had in moving the home forward.

During this visit, the registered manager, deputy manager and staff at the home told us they felt supported by the provider. One member of staff said, "We're getting so much support, I've never seen it before, they are supporting everybody. Things have changed. People are working together." Another said, "Recently things have got a lot better." They told us our last inspection report had been discussed … "People came down from head office and spoke to everyone and things were implemented after that." People said representatives from the provider company were more visible in the home … "I've seen a couple of people come in. You see more of the Priory come in. When it was [previous provider], I never saw anybody coming in." "There are people here most days."

At our last visit we found repairs were not undertaken in a timely manner because it took the organisation a long time to authorise these. The provider told us this should not be the case and they thought the issue was that staff did not understand the correct processes for authorisation. Since then, they have worked with staff to ensure they know how to request repairs and purchasing.

At our last inspection visit we had concerns that the quality auditing process was not effective in both supporting the registered manager to identify, and act on issues identified as requiring improvement. Since then, in response to the inspection, as well as being part of a range of changes made within the organisation, the quality assurance approach had changed. The registered manager was positive about the changes. They told us the approach was now to look at quality on a daily 'real-time' basis. They said a lot of

the paperwork linked to audits had been reduced and they were now more user-friendly. We saw how some of this was put into practice. One of the new quality initiatives was for the registered manager to have a 'Quality Walk'. During the walk around the home the registered manager checked the care being provided and if anything was not as it should be, it was addressed that day.

We saw that other audits, unlike previously, had led to actions which improved people's health and well-being. For example, the falls audits were now clearly showing the action taken in response to people's falls; and the number of falls experienced by people had reduced. The medicine audits showed medicines had been looked at in detail, and actions were being taken in response to the outcome of the audit.

At our last inspection we received mixed responses from staff about the management of the home. One response was that care staff felt they were blamed by the management and nurses if things go wrong. This time the staff we spoke with felt positive about management. One staff member said, "I think [registered manager] is a very nice person. She is very easy to approach. If you had a problem, she would go away and think about it and then come back and let you know what she could do for you. She is very understanding." Another staff member told us they had to reduce the number of hours they could work on a shift because of personal reasons. They said this had been accommodated by the registered manager. Another told us how the registered manager had given them another job role when they could not carry on providing care because of their circumstances. Another described the registered manager as "lovely". Other comments included: "[Registered manager] is very good and very supportive." "I like [registered manager] She has got a lot of respect."

We asked staff if they felt proud to work at Coundon Manor. One staff member responded, "Yes I am." They went on to say they were happier working in the home than they had been six months ago. When we asked why, they responded, "You can discuss things more and staff are nicer." When we asked what they would improve they said they would like more time to spend with people. Another staff member told us morale had improved in the home, "Now it is okay. Things have improved now so hopefully things are better for people and the girls [staff] are happier."

Staff spoke highly of the staff team, "The carers do work hard and really try their best." "We are a good team and we work well together." "All the carers work really hard and enjoy what they do." "The staff are really nice here and everyone gets on. If you have any problems you can speak to them."

The provider's action plan told us they would make sure there were planned team, relative and residents meetings to provide people with opportunities to engage with management and the senior management team. The resident meetings were in the form of a 'tea and chat' afternoon each month as people said they did not want to attend a formal meeting. During our visit we looked at the minutes of the meetings which had been held since our last inspection visit. These showed the provider was listening to people and their relations and taking on board the comments made. We saw at the staff team meeting, positive feedback was given to staff and staff were encouraged to be open and give their own feedback about working at the home. The registered manager said at the team meeting, 'I believe there is not enough value put on carers and nurses, but we do value you as without you all we would not have a care home.' The provider had planned meetings for the year.

A survey had been sent to 50 relatives, with 15 replies sent back. Of the 15 who replied, only one said the availability of management was poor, four felt management availability was adequate, four said it was good, and six said it was very good. A relative said to us, "Some time ago, I was asked to complete a form, to see if there were any areas that could be improved upon. Some of these things I mentioned have been actioned"

This meant the provider no longer breached Regulation 17 of the Health and Social Care Act.

Whilst we saw the provider had provided good resources to support the registered manager and staff to make improvements at the home, the improvements were recent and made at a time when there were less people living in the home than usual. There had not been sufficient time during the last inspection and this visit to be sure that the improvements were embedded into the culture of the home and would be sustained.

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