Amore Elderly Care Limited

Coundon Manor Care Home

Inspection report

1 Foster Road
Coventry
Warwickshire
CV6 3BH

Tel: 02476600860
Website: www.priorygroup.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection visit took place on 12 September 2017 and 25 October and was unannounced. We initially visited the home to undertake a focused inspection on 12 September 2017. This was because the provider had been in breach of a number of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at our last inspection in March 2017 and we wanted to check if improvements had been made. Because we did not see sufficient improvement during this visit we changed the inspection to a comprehensive inspection and went back again on 25 October 2017 to ensure we looked at all the areas of care we regulated.

Coundon Manor is a nursing home which provides both permanent accommodation, and respite or temporary accommodation to people who require nursing care and specialist dementia care. The maximum number of people the home can accommodate is 74. At the time of our inspection visit, 70 people were staying at the home.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we visited the home in March 2017 we rated the overall service as 'Requires Improvement'; however the majority of our concerns related to the quality of care provided on the ground floor dementia unit. During this inspection we had concerns about the quality of care on both floors.

At this inspection we found the provider continued to breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18, Staffing. This was because the staffing levels for the units were the same as they were when we visited in March 2017. The provider had agreed to an increase in staff during the day time, but this had only just been approved and not fully implemented. No increases to night time staffing had been considered and staff were not always available at the times people needed them. People were still at risk because there were not enough staff to meet their needs and manage the risks associated with their care. We had concerns about the level of staff and staff deployment on both floors of the home. There continued to be a high level of staff leaving the provider's employment at the service and high use of agency staff to cover for staff shortages. This did not promote continuity of care for people who lived there.

The provider continued to breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 14, Meeting nutritional and hydration needs. During our first visit there had been some improvements such as changes in the structure of mealtimes. People who required support to eat in their rooms, had this support before people who had their meals in the dining rooms were provided with their meals. This gave staff more time to support people with meals. On our second visit this had been changed back to the original routine. Mealtimes were rushed and people at risk of malnutrition were not always receiving the additional food supplements they required. People who could not drink independently were

not always getting enough fluid to keep them hydrated.

The provider continued to breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9, Person-centred care. The provider continued to have a high turn-over of staff at the home. This meant not all staff had received the 'creative minds' training to support them with dementia care. The home had to use a high number of agency staff and this meant people with dementia were supported by staff they did not know well. There were not enough staff to support people with more person centred activities.

People's medicines were not always managed well, there were areas of the home and equipment which was unclean; there was insufficient equipment to support people's safety with moving; and risks to people's health and safety had not always been acted on appropriately. This meant we found the provider breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12, Safe care and treatment.

Whilst individual staff were mostly kind and caring to people, we saw and were told of instances where people's dignity was not respected. This meant the provider breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 10: Dignity and respect.

The provider had a complaints procedure, however many of the complaints had not been responded to in a timely way. Some people felt their concerns were not listened to and addressed by the registered manager. This meant the provider breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 16: Complaints.

The provider continued to breach the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 breach of Regulation 17, Good Governance. The provider had not provided sufficient support to the registered manager or monitoring to improve the service. There had been limited improvements since our last visit but changes had mostly been reactive and in response to what other professionals had highlighted, instead of the provider and management team proactively identifying issues and making change happen.

Given the seriousness of concerns identified, the provider decided not to admit further people to the home and stated they would ensure comprehensive re assessments of people's care needs were undertaken should people look to return to the home following admission to hospital.

The overall rating for this service is inadequate. This means the service is in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service is not safe.

Staffing levels on both floors of the home were insufficient to meet people's needs during the day and at night. Known risks to people's health and well-being were not well managed. The premises and some of the equipment and furniture did not meet the expected standards of cleanliness. People's medicines were not always administered safely. Staff recruitment was safe.

Is the service effective?

Requires Improvement

The service is not always effective.

Because of the high turnover of staff, not all staff had received the training and support they needed to work effectively with people. People at risk of malnutrition and dehydration did not always receive the food and fluids to support them remain healthy. People who required restrictions to their liberty had this undertaken legally. Not all staff asked people's consent when carrying out tasks. People had access to other healthcare professionals when required.

Is the service caring?

Requires Improvement

The service is not always caring.

Most staff were kind and caring to people, but sometimes people's dignity and respect was not supported by the actions of staff. Staff were often too busy to provide anything other than task focused care and did not have time to meet people's emotional and social needs. Visitors were welcomed in the home.

Is the service responsive?

Inadequate

The home is not responsive .

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.

Is the service well-led?

Inadequate

The service is not well-led.

The provider has not provided timely support to the registered manager to make improvements to the service. Leadership of the home has been reactive rather than proactive in identifying issues and responding accordingly, therefore improvements in the safety and quality of service people received had not been made.

Coundon Manor Care Home

Detailed findings

Background to this inspection

We initially undertook an unannounced focused inspection of the ground floor dementia unit at Coundon Manor on 12 September 2017. This inspection was carried out to check improvements to meet legal requirements had been made after our comprehensive inspection in March 2017.

For this visit the inspection team consisted of an inspector and an inspection manager. We inspected the service against two of the five questions we ask about services: is the service 'safe', and is the service 'well-led'? This was because the service was not meeting some legal requirements.

During our September visit we spoke with the registered manager, the provider's quality improvement lead for the service, two nurses, two care workers and four relatives on the dementia unit. We spent time in the communal areas engaging with staff and people who were present. We also looked at three people's care records, supplementary records, medicine records and audits and checks carried out by the provider.

Prior to, and after our first inspection visit we received information from the public through our 'share your experience' web form. This was information from relatives of people who lived at the home and staff who worked at the service. We also contacted commissioners of the service (these are people who are responsible for ensuring the service their authority buys, provides good outcomes for people who use it), and other professionals who were involved in the home to check the service now met its legal requirements.

All information received about the service continued to give us cause for concern about the care provided on the dementia unit. We have shared our concerns related to our inspection findings with commissioners of the service.

Because of our concerns, we decided to change the inspection to a comprehensive inspection. This meant we looked at all five of the key questions we ask to make sure people received the care they required; and we looked at the quality of care provided on both floors of the home. To do this, we visited a second time on 25 October 2017.

This time the inspection team consisted of two inspectors, an expert by experience, and a specialist nurse advisor. An expert-by-experience is a person who has personal experience of using or caring for someone

who uses this type of care service. Our expert by experience had experience of supporting a person who lived with dementia. We started this inspection visit at 7am so we could also speak with night staff.

We spoke with seven people who lived at the home; six visiting relatives, the deputy manager (the registered manager was on annual leave), two of the provider's quality improvement leads, the cook, kitchen assistant, maintenance worker, housekeeper, three nurses, and seven care workers (this included night staff).

We also undertook a 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 to us. We looked at the management of medicines on the first floor, reviewed a further six care records, and looked at records which demonstrated how the provider made sure people who lived at the home were safe.

After our second inspection visit, we received three further calls from families of people who lived at the home who had concerns about the care provided. We also arranged, and spoke by phone with one of the activity workers to discuss with them the work they did at Coundon Manor.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection in March 2017 the provider was in breach of Regulation 18 of the Health and Social Care Regulations 2008 (Regulated Activities) 2014, Staffing. This was because there were not enough staff deployed on the dementia unit both day and night to respond to people's care needs and manage risks. The provider sent us an action plan which informed us by 30 June 2017 they expected staffing to improve.

Following our inspection in March 2017 we continued to receive concerns from relatives about the care their relations had received. One relative told us they had spent 1.5 hours in the lounge with 15 people. During that time they told us there were no staff present. They said in relation to staff availability, "Nothing has changed since the inspection in March, if anything it has got worse."

During this inspection we spoke to visiting relations about staffing levels. One told us, At week-ends they seem to struggle, there are not many staff on." They went on to say, "People like [their relative] need more stimulation; they just seem to sit there." Another relative said, "More staff is crucial, they just up and leave. At week-ends it is just chaos."

One relative told us they were concerned their relation was not getting their continence pads changed as regularly as they should and this left them 'soaking wet'. The person also needed staff to help them move position in bed, but this was also not happening as regularly as it should to reduce the risks of pressure damage to the skin. They were told by staff there were not enough of them to make sure those checks were made in a timely way. A second relative told us people were falling because they had forgotten they could not walk, and there were no staff available to make sure they were safe.

During the first day of our inspection we found there were less people walking around and displaying behaviours which could challenge others. However, we found safe care was still not always provided. For example, whilst walking down a corridor we saw one person in their bedroom showing signs of distress because it looked like they were trying to get out of bed and were stuck. There were no staff available to check this person's safety because staff were mostly in other people's bedrooms providing care, and the person was not able to use a call bell to call for help. We had to alert staff to the person's predicament.

We were concerned to find on our first visit, the level of staff on each shift had not changed since our previous inspection visit in March 2017. The provider's own internal 'inspection' of the service on 24 August 2017 had concluded more staff were needed on the dementia unit. This was five months after we had said the service was in breach of the Regulation. The registered manager told us they had seen an email the day before our visit confirming the staff numbers per day time shift could be increased by one, to seven care staff. It was concerning that this had not been implemented in a timely way.

Staff had been informed of the planned increase in staffing levels. They said in response, "If we had an extra carer it would be much more helpful as the staff member can sit in the main lounge. If just six carers they work in pairs, we do go and sit in the lounges sometimes but are often called away." "Seven would benefit

more, one person can support single people (people who don't need two staff to help with personal care) and assist at meal times." and, "An extra member of staff means it will give us a little bit of time, someone can spend time with them [people]."

However, the increase in staff was only approved for the day time shifts, and, at the time of our comprehensive inspection in March 2017 we had also identified concerns about night time staffing levels. There had been no changes to night time staff numbers since this visit.

When we went back on the second day of our inspection we arrived at 7am so we could speak with night staff and see how staff supported people early in the morning. When we arrived we went straight to the dementia unit. There were five people dressed and sat in the corridor next to the nurses' station. We had seen this at previous inspection visits and had been told this was because there were not enough staff available to monitor people if they were seated in the lounge or dining areas.

The night time staffing levels were one nurse and three care workers on each floor. The home was almost full and this meant the staff supported a minimum of 35 people on each floor. One member of staff on the ground floor told us nothing had changed since the last inspection. They said, "People who could move on their own a year ago, now need help."

The majority of night staff on both floors explained how much safer and more responsive they could be in meeting people's needs if they could have four care staff instead of three because this would mean they could provide personal support to people who required two people for assistance, in a more timely way.

People on the first floor told us they were also concerned about staff availability, particularly at night time. One person who stayed in their bed and required assistance with personal care told us, "When you want to go to the toilet you can't go. There's always one short (the person needed two staff to assist them and there was often only one staff member available)." They went on to tell us that it could be up to an hour before their request to use the bathroom was realised. Another person told us, "You can press the call button, you see its working but it takes them [staff] ages. You can't say they don't come but it takes them ages."

Night staff on the first floor told us, "If the home is full it is challenging. One more care worker would help. If people are bedbound we struggle to meet the needs of all the patients. Changing them makes it difficult." Another member of staff told us, "If I was a patient, I would not want to be lying in faeces. Staff are not being neglectful but they can't get to people all the time."

A member of day staff said of the night staff, "There are not enough. People are not being washed properly, particularly the bottom half."

A relative of a person on the first floor said, "The staff in the main are doing the best they can. The staffing levels are not to the level required, they are constantly fire-fighting." They went on to tell us that the nursing, care staff and cleaners were under, "A tremendous amount of pressure. I can't count the number of staff which have left."

At the time of our last inspection the registered manager told us they hoped by June 2017 they would have recruited to the vacant positions and there would be more stability in the staff group. Since our March inspection we received information from commissioners of the service that staff recruitment and retention remained a problem.

The registered manager confirmed they had not retained staff as they had hoped. The changes to

recruitment practice which they expected would lead to higher rates of staff retention did not happen. They told us they had again seen an increase in the number of agency staff (these are staff who are employed by a different organisation and who work temporarily in other services to support those services when they need additional staff support) used, but the level of agency use was now significantly reduced. However this reduction was recent.

The outcome of the provider's own internal inspection informed us for the week of 21 August 2017 the home's staffing was covered by 250 hours of agency care workers and 88 hours of nursing support. We asked what the level of agency nursing and care staff was for the week of our second visit in October 2017. We were told this was 258.5 hours of agency care work (this did not include the one to one care for two people at the home) and 121 hours of agency nurse support. We were informed this was slightly higher than usual because some of the agency staff covered for staff on leave due to school holidays.

Over the last few years at Coundon Manor, our inspection visits have highlighted a pattern of staff instability, where staff are recruited and soon after recruitment decide to leave, meaning agency staff have to be called in to make sure there are sufficient numbers of staff to keep people safe.

A member of staff told us, "Our problem is retention of staff as we have had some new staff who have literally only lasted half an hour. Dementia care is not for everyone, it can be hard." Another staff member echoed this, but for both floors. They said, "The problem is keeping staff. Carers have to work 12 hour days and they get paid poorly. We never seem to have the same faces."

On the second day of our inspection, the day time staffing level had increased for the early shift on the dementia unit, but the extra hours had still not been put in place for later in the day. The registered manager was still recruiting to fill the new post, and had not been given permission from the provider to cover the extra hours with agency workers or bank workers (staff employed by the provider who have no contracted hours, who are used to support the home when additional staff are required) until the post had been filled.

Previously, we raised concerns about the 'dependency tool.' This is used by the provider to determine how dependent people are on staff to support them, and how many staff are therefore required to meet people's needs. We were concerned the tool was weighted more towards people with physical dependencies than those who had social and emotional complexities as a consequence of living with dementia. The provider told us they would look at whether other tools would better analyse the number of staff required.

During this inspection the registered manager informed us that whilst other 'dependency tools' had been looked at, the provider had chosen to continue to use the same tool to establish required staffing levels. At this visit we also noticed the dependency tool was not being used properly. For example, one person's dependency had been scored as 'medium' but staff had not completed some parts of the assessment required. We determined if this had been done, the assessment of need for this person would have been a lot higher.

This meant the provider continued to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

We looked at the care records of the person we found in distress. Their care records told us the person was at risk of falls, and had previously fallen and fractured their hip. Their care plan informed staff to provide 'safety/regular checks, supervision and increase observations'. We were told by staff the person was 'being observed' on an hourly basis but these had not been documented. It was not clear how an hourly observation was going to reduce this person's risk of falling.

In one of the smaller lounges, we saw a person stand up because they wanted to blow their nose, they had nasal secretions running down their face. No staff were present to assist them. The person walked towards a dining room table, picked up a plate, blew their nose and spat into it. They then walked around the dining area and into the corridor. The person had taken their shoes off and walked in their socks. According to this person's care plan, they were at high risk of falls. Walking in socks meant they were more at risk of slipping and falling. We drew the nurse's attention to the person who confirmed they were not safe and immediately went to get their shoes and helped to put them on.

Since our visit in March we have been notified of six people who received hospital treatment as a consequence of fractures resulting from falls. Most of these people had been identified as being at a high risk of falls. We were concerned that whilst people had been assessed as being at a high risk, they were still falling and injuring themselves. We asked the registered manager to send us the analysis and actions taken in response to each person's falls. We found many of the falls were in the corridors and in the communal rooms. On the second day of our visit, we looked in detail at the support given to two people who had been identified by the provider as having had a number of falls.

One person on the dementia unit had fallen 10 times between June 2017 and October 2017. Records showed the actions identified to reduce the risks were 'staff awareness', 'care plan' and 'general observations'. We asked what this meant, and were told by the deputy manager that, "Staff need to be aware of [person]'s whereabouts." Staff told us they tried to observe the person's whereabouts but this was not always possible due to the layout of the home. This person had not been referred to an occupational therapist to see if they could provide further support to reduce their risk of falling. The deputy manager said they would do this. The person was able to communicate with us, and explained, "I am a bit black and blue (bruising was on their arms from recent falls), the girls do try and encourage me to sit down but I choose not to. I know I can fall but I choose to walk around."

The second person who also lived on the dementia unit had fallen 16 times in the last few months. Many of these falls had been un-witnessed and the person had been found on the floor by staff. The same measures to control the falls risk were in place, 'staff awareness', care plan' and, 'general observations'. Staff told us they knew to observe the person every hour but this was not always possible as they were busy completing other tasks. This person had a medical condition that also contributed to their falls. The home's staff had referred them to a specialist nurse to see if they could help reduce the amount they fell. However, the referral had been made mid-September 2017 and since then, the person had fallen a further four times. Staff had not followed this up. The deputy manager told us, "It's disappointing; I will chase it up today."

A member of staff told us, "People fall over because we can't watch them all the time. It makes me feel guilty but I can't do everything."

After our second visit to the home another relative contacted us and told us how they had watched a person on the dementia unit try to get up out of their seat ready to walk. They told us the person was unsteady on their feet and staff tried to get them to stay sat down because they were busy assisting other people. The relative explained they had to intervene by distracting the person because they were worried the person would fall if this had not happened.

Prior to our first visit we received information from three different sources who told us staff were not safely moving people. They said staff were 'drag lifting' people (lifting people under their arms, putting pressure on the underarm sockets) instead of using the correct equipment to support people to move safely. Following our visit, we received further information which again informed us staff had been seen drag lifting a person. They told us the person required the use of the hoist. They told us they thought staff were busy and did not

have the time to get the equipment to move the person safely. So instead they lifted the person up under their arms and dragged them to the required place and position.

During both visits we checked how staff moved people who were unable to move independently. We saw safe moving practice. However on the second day of our visit we saw staff took a long time to support a person on the dementia unit who had fallen in the lounge because staff could not locate the equipment they needed to move the person. The person required a hoist, a sling and their wheelchair to support them back off the ground, safely. Whilst staff quickly found a hoist it took a further 25 minutes to locate the person's wheelchair and the right size sling. We heard one of the nurses say out loud, "We shouldn't have to look for slings like this." A care worker replied, "We can never find slings. They get taken upstairs and don't come back."

During this time, we heard the nurse give clear direction to some care staff to leave the lounge (in order to support other people), but this instruction was not followed. Six care workers stayed with the person until they were moved back to safety. This meant for 25 minutes, only one care worker was available to support other people on the unit. We spoke with one of the provider's quality leads about this. They told us, "Staff were being a bit too caring, they wanted to show they cared." They acknowledged the deployment of staff during the incident presented a risk to others.

We found people who required a sling did not have one individually allocated to them (a sling is what a person sits in to make them more comfortable when lifted by a hoist). Instead slings were used for multiple people in the home. This could have contributed to the issue we saw with the delay in staff locating them. The lack of easily accessible equipment could lead staff to move people unsafely if they were under pressure. Furthermore the communal use of slings could also increase the possible risk of infection being transferred from one person to another as slings were used when assisting people with personal care.

Some of the care records we looked at did not give enough detail to support staff's knowledge of the person to help them move the person safely.

For example, we saw one person often leaned forward until they were almost bent double when they were in a sitting position. When the person used a hoist, staff spoken with knew they leaned forward and made sure they protected the person from banging their head on the metal arm of the hoist, however this information was not in the person's care plan. This meant staff unfamiliar with people, for example, agency staff or staff new to the home, might not be aware of this important information. There was also no assessment in this person's file to show they had been seen by an occupational therapist for a chair which would help them sit in an arm chair more safely.

The care plan of another person who also leaned forward, informed us the person had been assessed to use a recliner chair, but we saw the person was sitting in a wheelchair. By speaking with the nurse we found the person was no longer able to use a recliner chair because their condition had changed and it was considered too risky, but the care record had not been updated. The person was also moved through the use of a hoist with a sling, but the care record did not inform staff of the size of sling they required. It told staff to use 'the correct size' without saying what this was. This meant staff unfamiliar with the person would not have the right information to move the person safely.

Another person was using a recliner chair and we asked why this was. We were informed that nursing staff thought the person was safer in that type of chair, but they had not contacted the occupational therapists who were the specialists in making these decisions to check this was the right type of chair for the person.

We saw staff move people into the lounge in their wheelchairs. We found when two people were moved; their feet dragged behind on the floor and were not placed on the footplates to keep them safe. A care worker was able to explain why people's feet were not on the footplates, but no referral had been made to occupational therapists to see whether a more appropriate wheelchair could be used.

After our first visit we received concerns from a relative that their relation used a wheelchair with a lap belt and they had not previously needed one. We asked one of the commissioners of the service to look at this person's care when they visited the home. They found staff had made the decision to use the chair instead of getting the person's mobility assessed by a specialist.

During our first visit to the home we saw two of the mattresses used by people at high risks of skin damage through pressure sores, were not set at the right setting for their weight. This increased the risk of further skin damage. We found that the system for staff to check that the settings were correct was ineffective. Despite informing the registered manager and the quality improvement lead of this on the first day of our visit, on our second visit to the home we continued to find mattresses not at the right setting for people's weight.

We checked to see if medicines were managed safely. Prior to our inspection visit we received information from a relative that their relation had received the wrong medication. We also received a notification from the provider to inform us that one person had not received their medicine for two months. We were aware from speaking with the registered manager, commissioners and the advance nurse practitioner for the home there had been some problems with the supply of medicines to the home. This was being addressed by the registered manager with a meeting involving the dispensing chemist.

We looked at a sample of medicine records on the ground floor dementia unit during our first visit and based on this sample, we were satisfied that medicines were administered safely. During our second visit, we saw one of the nurses on the first floor walked along the corridor with a tray carrying five pots containing medicines. These medicines were for five different people, and the nurse went from one person to the next giving them the medicines the nurse thought was theirs (as there was no record to check they were giving the right medicine to the right person).

The nurse acknowledged to us after the medicines had been administered that they knew they had not administered the medicines in a safe manner. This was because all staff who administer medicines are trained to only administer medicines to one person at a time. This reduces the risks of administering the wrong medicine to the person. The provider's quality lead was informed of this poor practice and told us they would ensure this was dealt with.

The home's staff carried out their own checks on the medicine administration records to ensure staff had administered people's medicines as prescribed. Their audit had found a small number of 'gaps' on the charts used by staff but nothing which would place a person at risk. We found no gaps in the recording of medicine administration which we sampled during this inspection.

However, on the first floor, we did not see records to demonstrate that prescribed creams had been applied by staff. Staff told us they, "Always sign for applying creams," but this was not what we saw. For example, on person's chart had not been completed since August 2017.

For people who were prescribed medicines on an 'as required' basis, medicine plans explained why the person needed the medicine, and how to determine whether the person needed their medicine if they were unable to communicate with words. However, we spoke with one person on the first floor who received

medicines 'as required' for pain. They told us staff pressures affected whether they received their medicines. The person said they did not always receive their medicine because staff were "so busy".

There were many parts of the home and furnishings which were not clean. For example, a room labelled 'Store Room' on the first floor had a toilet (a dirty looking toilet seat and no toilet seat lid) shower and wash basin plus a dirty hoist, hoist slings and a person's clothes on the floor. An 'assisted WC' which was used by people on the first floor contained several red bags piled on the floor (soiled clinical waste) and white dirty linen bags. Throughout the home we saw wheelchairs in use were dirty as were bedside tables. The recliner chair one person was using, was extremely unclean.

This meant the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

We checked the provider's recruitment practices, by looking at the recruitment files of two new staff and by speaking with staff new to the service. Prior to new staff starting work at the home, the registered manager checked whether the Disclosure and Barring Service (DBS) held information about individuals; and waited for two references from previous employers. New staff confirmed they were unable to start working at the home until their 'clearance' checks had been completed. This was to ensure new staff were of good character and suitable to work with people who lived at the home.

The premises were secure and records demonstrated there were regular checks for fire safety, gas and electric safety, water safety and to make sure the equipment used was mechanically safe. On the day of our visit, the fire alarm sounded because toast had burned in one of the dining rooms. Staff demonstrated a good knowledge of the fire procedure.

People had individual evacuation plans to help fire and rescue services evacuate the premises if the need ever arose. However, one person in the home used oxygen. The care workers we spoke with did not know how to evacuate the person or understand how the person would be evacuated with their oxygen.

Staff we spoke with understood the principles of safeguarding people who lived at the home from harm, and knew their responsibilities to report any unsafe practice. Where staff had identified safeguarding incidents, these had been reported to the local authority safeguarding team and notifications sent to us at the CQC.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2017 the provider was in breach of Regulation 14 of the Health and Social Care Regulations 2008 (Regulated Activities) 2014, Meeting Nutrition and hydration needs. This was because staff did not have the time to support people who needed assistance, to eat and drink, and people with dementia were not supported to know what the choices of food were. Mealtimes were rushed and people were not given the time they needed to eat and drink at their own pace.

Since our inspection in March 2017, three sets of relatives contacted us because they were concerned people who could not independently eat or drink, were not getting the food or fluids they needed.

As part of our 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. The dietician told us they had met with the deputy manager (after the first day of our inspection) to inform them of their concerns.

When we went back to the home for our second inspection visit we spoke with the chef. They told us staff had "got better" at making sure people had their milkshakes and snacks. One member of staff told us, "People do get enough to eat. We make sure of that. We offer snacks and bits of chocolate between meals if people are at risk of losing weight." They went on to say, "The cook makes milkshakes up for some people. It's a good way to get extra calories into people especially if they don't like eating big meals." We contacted the dietician after our second visit who told us they were monitoring progress and would be returning to the home in November to check whether improvements had been made.

We looked at how staff supported people with their meals and drinks. At our inspection in March 2017 we found lunchtimes were hurried and staff did not have the time to support people with their meals. After the March inspection we were informed lunchtimes had been reorganised so those people who required their meals and drinks in their bedrooms, had these first and those who ate in the dining rooms had their meals afterwards. This meant staff had more time to support people with their meals.

During our first inspection visit in September 2017 we found lunchtimes ran more smoothly than previously and were satisfied people had the support required to help them with their meals. However, on our second visit in October we found that, in a short space of time, this improvement had not been sustained. The meal time appeared hurried with staff coming back and forth into the dining room to collect the meals of those eating in their rooms, at the same time as people in the dining room were eating their meal, and requiring support.

We asked a member of staff why there had been a change in approach. They told us the new chef did not

like them providing meals to people cared for in bed first, "despite the fact everyone else thought it worked really well." They stated that because of this, all people received their meals at the same time. We informed the provider's quality lead about this who told us they would investigate, as they said the chef should not be making these decisions. It was of concern that this change back to the original routine had not been acted on by the provider or management team.

Most people told us they were satisfied with the food available and it was plentiful. Whilst meal time was disorganised during our second visit, we saw most people who ate in the dining rooms finished their meals. One person on the first floor, who ate their meal in their bedroom, told us their meal was often cold. They told us they would send them back uneaten and they would return still cold and consequently uneaten. A professional visitor to the home had also told us that they saw a person complain to staff their meal was cold. They told us the staff member kept on insisting that the plate was hot, but did not deal with the fact that the meal on the hot plate was cold.

We saw two people in the dementia unit who, whilst provided with a drink, did not have the drink placed in front of them with their main meal, and staff did not encourage people to drink by offering alternative choices. One person did not eat their meal, and whilst we saw staff encourage the person to eat the meal in front of them, they did not try to encourage them to eat by showing them a different meal which they might have preferred.

We saw drinks were readily available to people but we were concerned people who could not drink without assistance were getting the support they needed. One relative told us they had just given their relation a drink because they looked thirsty. They said they could not prove anything but said the person had drunk it all very quickly and this made them think they had not had a drink that morning. They went on to tell us they felt their relation often did not get the food and fluids they needed.

A person told us that cups of tea were offered regularly and they were encouraged to drink, but they added if they felt thirsty at night and unable to reach a drink they would not call night staff and would prefer to put up with feeling thirsty. Another said they would sometimes get thirsty, and when asked what they did, they said, "I would sit down and behave myself and wait for a coffee. I have to wait 10 minutes, that's a long time."

After our second inspection visit, phone calls from relatives informed us of continued concerns relating to food and drink. One told us staff did not support their relation who was partially blind. They said, "They drop your dinner in front of you and you are left to it." They explained they had recently witnessed a person in the dementia unit; try to eat a sandwich with a fork. The relative told us they were concerned the person's sandwich would end up on the floor and whilst there were two staff in the dining room, the staff were busy with other people. So this relative asked, and was given permission to cut the sandwich up to help the person. The person was then able to eat it. However it was because of the actions of the relative rather than the staff that this happened.

Another relative told us their family came to the home most days to support their relation to eat because they could not be assured staff would give their relation the support they needed at mealtimes. A third relative said their family member was often told by staff they would go and get a cup of tea for them, but never came back with the expected drink.

A commissioner for the service who frequently visited Coundon Manor also told us they had concerns that people who could not independently drink were not getting enough fluids. They said they often saw people with dry mouths, and whilst there were jugs of juice available to people, if staff did not support people in

having the drinks, they would not receive them.

A member of staff said to us, "I can't be sure people get enough to drink if I am honest." They said a 'tea trolley' went round at 3pm but because there were so many people to get around and because it was only one person who worked the trolley, it was often rushed and the amount people drunk was not always observed.

At our last inspection in March 2017 we were concerned that the hostesses who supported staff with people's eating and drinking; finished work at 2pm. In addition to there being no hostesses there was also a reduction in care staff in the afternoon. The provider, in their action plan, said they would review this. At the time of this inspection visit, we found no changes had been made.

We looked at the care files to check information available gave staff clear information about people's food and fluid requirements. One person on the first floor had diabetes and on a high protein diet. The handwriting of the nurse, who had written this care plan, was almost impossible to read and as such we could not work out what was written. With a high use of temporary staff it was important that care plans could be read so they understood people's dietary needs.

On the ground floor, the two people's care plans we looked at on the second day of our visit, informed us the people were at high risk of losing weight and becoming dehydrated. But, staff confirmed to us neither of them were at risk as both ate and drank well. We were concerned the assessment had identified them as at risk, but they clearly weren't.

This meant the home continues to be in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

Because there had been a significant change in staffing at the home, we checked to see how many of the staff had received the training the provider considered essential for staff to meet their health and safety responsibilities; and the support new staff had received on starting work at the home.

We talked to a member of staff who had been working at the home for a few months, who told us they had never worked in the care field before. When asked, they told us their induction was, "Not great." They told us they worked two shifts alongside a more experienced member of staff. Since then they had been on the rota working in a pair with another member of staff. They explained to us the care staff they worked with did not initially know they were new to care. They told us they felt they had to pick things up as they went along and had not yet had a meeting with a senior member of staff to discuss their work performance and how they were getting on with the job.

We spoke with two other staff who had worked at the home for less than a year. Both had worked four shifts prior to being part of the staff rota, and both had previous experience of working in care. They felt this was sufficient to support them in understanding people's needs. However, they also said they did not get supervision [individual meetings with a manager]. One told us, "I rarely get supervision. I don't think anyone does. I can go and speak with managers if I want to though."

We asked the provider's quality improvement lead for the home to tell us how many staff had received supervision for their work. They told us, 12 of the 39 care staff on days, and four of the 12 care staff on night duty had not received supervision since March 2017, and the remainder had received supervision once. All nurses had received supervision once since March 2017. They said that following the inspection they would be introducing a system to remind managers to support staff with supervision, and that it remained a 'key

priority' for staff.

Since our last visit, the provider had instigated 'creative minds' training for all staff to improve staff understanding of dementia care. This did not start until June 2017. Since our last inspection in March 2017, many staff had left their employment at the service. This led to a lack of continuity of care with an increase in the number of agency staff covering care provision, and new staff starting work at the service without the dementia care training.

More training took place for new staff in September 2017; and some staff had also taken part in training to help them de-escalate tension and reduce behaviours which could challenge others. A member of staff told us about the dementia training they had. They said it was good. They explained they had been taught to use distraction techniques such as taking people for a walk around the garden to reduce their level of anxiety. When asked if this was always possible they replied, "No". They told us they were very busy and did not have time to support people on an individual basis.

Another member of staff who had worked at the home for longer than a year told us they felt there was a lot of training. They said, "I've had lots of training, dementia, food hygiene and hoist training." They went on to say, "Training is plentiful but mostly on-line, it can be hard to find the time to do it but I manage."

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.

At our last inspection visit some staff had not completed MCA training. The registered manager told us they were still 'struggling' to ensure all staff had received this training. They told us staff were scheduled to complete the training, but it was postponed because they needed to prioritise completing infection control training. A member of staff who had completed their MCA training said to us, "I understand that we can't presume people don't have capacity."

We looked at care plans and saw people's capacity to make their own decisions had been assessed. These informed staff whether people had the ability to make day to day or more complex decisions; but there was little detail about what day to day decisions people could make and what fluctuation in capacity staff needed to check. Where people had their liberty restricted the required authorisations were in place. We saw one DoLS supervisory order was due to expire on 1 November 2017. The nurses did not know if an application had been resubmitted to enable the person to legally continue being deprived of their liberty after this date.

At our last inspection staff did not always ask for people's consent before they undertook tasks. For example, they put clothes protectors on people at lunchtime without checking this was okay with the person first. During this visit we saw similar issues. For example, whilst people told us care workers asked for their consent before undertaking any task, we saw in the ground floor some people were not asked if they

wanted a clothes protector. As the lunch time meal came to an end, a care worker started to remove one from a person who was still eating their pudding. They resisted by saying, "Hay, you cheeky bugger."

People's day to day health needs were usually met by the nursing staff on duty. However, we found some instances where their health care support was not being delivered by staff as it should. On the first floor of the home one person had severe damage to their skin (this was acquired prior to living at Coundon Manor). Because of the severity of the skin damage, nursing staff used a specific type of vacuum therapy which used an electric pump to provide pressure to the wound. We found records which showed that during the night the equipment regularly malfunctioned and the nurse response was to just switch it off, without taking any action to find out what caused it to malfunction.

Whilst the skin damage was decreasing because of the therapy, the person had missed out on a number of hours of therapy once the equipment had been turned off. We informed the provider's management team of this, and the maintenance worker checked the equipment. They found the problem was easily remedied, and this meant if staff had been proactive about this sooner, the person would not have needed to go without their vacuum therapy for those hours. The provider informed us after our inspection visit they had instigated a process to ensure the vacuum therapy was in constant use.

On the ground floor dementia unit, we also saw a person with a skin tear about the size of a penny. This had not been identified or acted on by staff. The tear was open and no dressing had been applied. The person was prone to fragile skin. A relative contacted us after our second day of the inspection. They told us they were concerned because a few weeks ago their relation's finger had become swollen and blue. Recently their relation had also damaged their elbow and there was a concern that no staff seemed to know why this was.

We spoke with the Advanced Nurse Practitioner of one of the GP surgeries which people who live at Coundon Manor use. They told us they visited the home once or twice a week to see patients who may need further medical support and referral to the practice's GPs. During both visits we saw a speech and language therapist (SALT) who was visiting people on the dementia unit; and a MacMillan nurse who was visiting people on the first floor on the second day of our inspection. The SALT told us they usually visited the home around meal times and saw the same nurses each time. They felt the nurses had a good understanding of people's needs. The MacMillan nurse told us the staff were very helpful, referred people to them appropriately and did what they were asked to do.

By looking at records we saw that other healthcare support had been provided to people. This included dental, optician appointments; as well as healthcare referrals for other medical needs.

Requires Improvement

Is the service caring?

Our findings

At our last comprehensive inspection in March 2017, 'caring' was rated as requires improvement. This was because staff who worked on the dementia unit told us there were not enough of them to engage meaningfully with people.

During this inspection, people and relatives on both units expressed some concerns about staff attitudes and practices. Most people we spoke with commented on how busy staff were and how this impacted on the care they received. One person said, "They seem not to be doing things wholeheartedly. They do what's needed but without heart."

One person became tearful when they talked to us. They said they felt treated without dignity. They went on to tell us they wore continence pads but could use the toilet. They said that staff had told them to, "wet" themselves rather than support them go to the toilet. They said, "I'm [age] and I don't want to wet myself." They also told us some staff referred to the continence pads as 'nappies'. The person found it particularly upsetting when staff talked about 'changing the nappy' in front of family members.

We saw many patient, caring and respectful approaches from staff to people who lived at the home, but we also saw interventions which fell short of 'caring'. For example, during this inspection we were in the dining room on the first floor seeing how people were supported with their meals. We saw a member of staff go over to a person who was in distress. We could not hear what the person said, but heard the member of staff respond with, "You'll need to do it in your pad." They then left the person. To confirm we had heard this correctly, we went over and asked the person why they were upset. They told us they needed to go to the toilet. On seeing us check what was wrong, the member of staff came back over to the person to take them to the toilet and said to us, "It's really busy, and this is a habit."

During lunch time, again on the first floor, we saw one member of staff who was supporting a person with one to one care, stood by the table next to the person whilst they and other people sitting at their dining table ate their meal. They were not supporting the person to eat, but because of the one to one care had to stay close by. There was space at the table for the staff member to sit at the table but they stayed standing. Sitting next to the person would have been more respectful to the person whilst they were eating.

We also saw a care worker on the first floor supporting a person to eat who was eating their meal in their bedroom. The care worker was standing and giving the person spoons of food, instead of sitting down with them in a supportive way. Similarly, other staff on the floor supported people to eat, and whilst they were not hurrying people, they did not use this time as an opportunity to engage with people.

In the first floor corridor we saw a staff member being very kind to one person, but at the same time was sharp in voice tone to another. A person was sat on a chair and looked like they had an injured sore leg. The person went to get up off the chair and walk off, which the care worker spotted. They encouraged the person to remain in their chair and offered to get them a cup of tea, which they did. On bringing the tea back, they looked over to another person who was sitting nearby and without using their name sharply

asked, "Do you want one as well? A coffee?"

On the ground floor dementia unit, we did not see staff engage with people in a caring way, other than when providing personal care. On both days of the inspection, apart from when an organised activity was taking place; we saw little engagement with people in the lounge area. For example, on one occasion we were sat in the lounge with two staff members present. They were sitting next to each other in arm chairs, they did not engage with people or each other until the nurse entered the room and said, "Come on speak to people." The staff then began to engage with people by asking questions such as, 'are you okay?' and 'did you enjoy your lunch?' but this stopped once the nurse left the room.

A commissioner told us after our first day of our inspection, they had visited the home and saw four staff in the ground floor lounge with a group of people. None of the staff were using this time constructively to engage with people who lived in the home.

Relatives had mixed opinions about the care provided by staff. One relative said, "Staff are really kind but there is only so much they can do because they are so stretched." Relatives of a person who had recently came to the home and was on 'one to one' care during the day said the person was happy with the staff and had really settled in. Another relative who had previously told us they were not happy with the care provided, told us they felt care had 'improved'. Others commented staff were "Always willing to help" and "Staff are very nice."

Staff knew they were not always as caring as they would like to be. One said, "I do try and cheer people up, I sing songs and tell jokes which makes people smile. I really want to do a good job. More of us would make me a better carer as I wouldn't have to keep rushing around." Another said, "I don't have enough time for people. [Person] wants someone to sit and hold her hand or put some rollers in her hair. We just can't do it for her…because we don't have time she gets tearful and frustrated. I could cry for her sometimes it's sad to see."

This was meant the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Dignity and respect .

We were told about two thirds of people on the first floor were receiving 'end of life' care. One relative, whose loved one passed away on the day of our visit, told us the care had been 'fantastic' in the week their relative had been at the home. The person's death had been expected. Staff treated the person with respect and dignity at the time of their passing.

The MacMillan nurse we spoke with, told us that Coundon Manor was better than many she visited, but staff were always very busy. However, another relative who spoke with us after the inspection visit was less pleased with the care their relation was receiving at the end of their life. They thought their relation was worried to ask staff to do things for them in case they 'rocked the boat'. The family felt there was often no staff around to support the person with their needs.

Visitors were welcomed at the home during the day and evening. During both inspection visits we saw many relations at the home visiting their loved ones.

Inadequate

Is the service responsive?

Our findings

At our last comprehensive inspection in March 2017, responsive was rated as 'Requires Improvement' and there was breach of Regulation 9: Person centred care.

During our comprehensive inspection in March 2017, we were told by both staff and relatives there was a problem with the supply of continence products. We were told towards the end of the month people could be using continence pads which were the wrong size for them because the correct sized pads had been used before the next delivery was due. This meant some people experienced discomfort because they were 'soaked' as they had been given a pad which was too small for them.

The provider's action plan told us to address this, senior care workers would deliver pads daily to the person's room, and the provider would purchase additional pads as necessary.

At this inspection people, relatives and staff told us there continued to be a problem with the availability of the correct continence products. One staff member said, "The home has run out of the right sizes of pads. People have been given the wrong sizes for their prescription." Another member of staff confirmed the home was short of incontinence pads. They said, "We only had size five (small) for both floors." They explained this had been a 'struggle' for staff for two weeks. A relative told us that sometimes their mother did not have continence pads to put on, and they had been told by care workers that this was because, "The night staff are using the wrong pads." Staff told us this was a continual problem, not just a one off. This meant there continued to be issues with people receiving the right products to meet their needs.

During our inspection in March 2017 we were told that people were not receiving showers when they wanted them. The provider's action plan told us shower charts would be reviewed daily.

At this inspection we asked staff whether people received showers when they wanted them. One member of staff said, "We have a shower list. It's flexible though so if people want more and we have the time they can have one." However, they went on to say, "It's not always possible though and some people do miss out. We were told to offer showers during the afternoon, but people want them either in the morning or at night time."

We noticed there were a number of people who were dressed and had personal care who had dirty finger nails. A care worker told us staff had no time to carry out anything other than basic care and this did not involve nail care. We also noticed that one person, whose family told us, and care plan said, liked to be clean shaven, was still not shaved after lunchtime.

At our previous inspection in March 2017 we were concerned the specialist dementia unit did not provide specialist dementia care as advertised by the provider, because staff had not been sufficiently trained, and support was not person centred. At this inspection we did not see the care provided had improved in relation to person centred care.

During the two visits for this inspection we saw two organised activities take place. One was with an external fitness coach who came regularly to the home to provide physical activities people could undertake from their armchairs. The second was with the activity co-ordinator where people sang and reminisced. We saw people enjoyed both activities, however these were the only times on both days where there was any real engagement between people and staff outside of staff providing personal care and some engagement at meal times. The remainder of the time people were either left in the lounges or in their bedrooms, alone without staff support or encouragement (unless being provided with separately funded one to one care).

One of the activity workers told us about the range of organised activities provided. They said there was always an organised activity in the morning and afternoon for those people able to participate. These included arts and crafts, cooking, music and movement. The activity team also had some time later in the afternoon from 3pm to 4.30pm to support people with one to one activities. However, we were told this was not possible for every person every day. One to one activities included reading books to people, painting people's nails, and providing emotional support to people receiving end of life care. The activity team also had use of a minibus which they used to support people who wished to, to go on trips outside of the home at least once a week.

The activity worker told us they had started to use 'Doll Therapy' for people on the dementia unit. Dolls are looked after as 'living beings' by some people with dementia. They can give people with dementia a sense of purpose, and remind them of earlier times when caring for family members. This therapy can reduce anxiety in some people. The activity worker told us this had worked really well with one person in particular who still lived at the home, but staff had been told by the provider's dementia specialist, to remove the dolls from the unit until there was a pushchair or cot to place the dolls in. We asked whether these had been purchased and were told they had not. The dolls had been removed four months ago.

On both floors of the home, the new nurse clinical leads were re-writing care plans. This was because they recognised care plans were not all person centred, and the needs of people who lived in the home had changed, but care documentation had not reflected the changes. This reflected what we found in some of the care records we looked at.

We asked people and their relatives if they were involved in care planning and in decisions about their daily care needs. One relative told us their relation had a sinus problem and it was worsening because their nose was running all the time. When they had enquired about this, staff told them the person did not like them applying their nasal spray. The relative said the person could apply the nasal spray themselves more comfortably. It appeared that staff had not discussed this with the relation to find a solution.

Another person told us they knew they should have a plan but had not seen theirs. A relative told us they had given staff information about their family member's care needs and preferences but had not seen a plan as a consequence of this.

During this inspection we did not find the home's staff responsive to concerns identified. On our visit in September 2017 we informed senior staff that some of the mattresses were wrongly set for the weight of people. This continued to be the case a month later. During the second day of our inspection, one of our inspection team informed staff on the first floor that a person was at risk of developing a pressure sore on their foot because their feet were tight up against the bed end. Staff told us the person was able to move themselves, but we checked four times during the course of the day and the person was in the same position all day.

One person's chart for repositioning did not give the time frame between each time the person was

repositioned. When asked how care workers knew when to reposition the person we were told by a care worker, "We just know". Handwriting within care plans was, at times extremely difficult to read. We discussed this with the senior management team who advised that they would take supportive action to address this

This meant the provider continued to be in breach of Regulation 9 of the Health and Social Care Regulations 2008 (Regulated Activities) 2014: Person centred care.

Relatives we spoke with prior, during, and after our inspection visits were mostly not satisfied with the way the registered manager had managed their concerns. One relative told us after a period of dissatisfaction with the way their concern was managed, they were now happy with the care their relation received and felt they now had a good relationship with the manager. However, others told us they felt the registered manager could be 'defensive' when they identified problems, and did not listen well to their concerns or complaints. One relative told us the registered manager, "attempted to defend and argue every issue." Another told us they had "given up" trying to talk to the registered manager as they felt the manager did not want to hear their concerns. A third told us they had informed the manager of their concerns and, "It goes alright for one or two days, and then it goes back to normal." A person told us, "I feel I complain too much." They did not specify their concerns to us but said, "There's something not right here. I don't know what."

In July 2017 we received a complaint from a relative. Because of some of the issues identified, we sent the complaint to the provider for them to investigate. We received the outcome of the complaint at the end of September 2017. We did not consider the complaint response fully met the provider's responsibility under the 'duty of candour'. For example, the provider said that as a result of the complaint, they had taken action to review how they delivered support at meal times, and had introduced an additional member of staff to the dementia unit. But both of the changes they said were as a consequence of the complaint, had already been identified in April 2017 in their CQC development plan. And the change regarding additional staffing had only been agreed in September 2017.

Other complaints had not been responded to in a timely way. The provider's own internal inspection outlined that as of 24 August 2017 there had been 22 formal complaints received. It reported there had been 'significant delays in the response times due to other levels of management involvement in the complaint responses. Several holding letters have been sent out as our policy timescales have not been met.'

This meant the provider was in breach of Regulation 16 of the Health and Social Care Regulations 2008 (Regulated Activities) 2014: Complaints.

Inadequate

Is the service well-led?

Our findings

The home has a registered manager. They were registered with the CQC in January 2016 to be the registered manager of Coundon Manor.

The provider has a history of failing to meet the standards and regulations expected for the provision of good quality care. Inspections in 2012, 2013, 2014 and 2015 found breaches of the regulations. As a consequence of the inspection in 2015 the home went into special measures. Six months after this inspection in 2016, we inspected the home again and found the home had improved enough to remove the breaches, but the quality of care provided to people still 'required improvement'.

At our last comprehensive inspection in March 2017, we found the quality of care had again declined. The provider was in breach of Regulation 17 of the Health and Social Care Regulations 2008 (Regulated Activities) 2014, Good Governance. This was because the systems in place to assess and monitor the quality and safety of service people received was ineffective. People had been put at risk because there was not enough staff who worked on the dementia unit to keep people safe. Staff who worked on the dementia unit had not completed any specialised dementia training, and this was in contrast to the provider's website which stated staff 'have a detailed understanding of the unique nature of dementia' and the nurses had 'additional specialised training in dementia care'. We also found in our last inspection and in other previous inspections people who needed support to eat and drink had not always received this support.

After the March 2017 inspection visit we requested to meet with a representative of the provider with the registered manager. The representative was not available on the day of the meeting therefore we met with the registered manager in May 2017, and had a telephone meeting with the quality improvement lead for the home on 6 June 2017. This was to discuss the last inspection and in particular, to seek re-assurance that our concerns about the quality and safety of care provided on the dementia unit would be addressed as a matter of priority. It was also to seek re-assurances from senior management they would support the registered manager to prevent a further a decline in the quality of care provided. We were given these re-assurances. This was because the home had been in special measures in 2015 and we wanted to be assured the provider was aware of the real concerns we had about this unit.

The provider had made structural changes within the organisation and this meant the registered manager did not have the support of a consistent regional operations director, and instead received more sporadic support from a regional director from a different region. The re-assurances we had been given about the service and the plans they were looking to implement which we thought would improve the service had not been realised.

Since our last comprehensive inspection we continued to receive concerns from relatives, people who have worked at the home, professionals who have visited the home and commissioners of the service. Most of the concerns had been about the quality and safety of care provided in the dementia unit.

At this inspection the provider has not met any of the breaches of Regulations identified at the previous

inspection. The provider and registered manager had not ensured all the people who lived in the home had the nutrition they required, had person centred care, and had enough staff available to meet their needs. We also found the provider to be in breach of three other Regulations, 'Safe care and treatment,' 'Dignity and respect,' and 'Complaints'.

The provider had systems to check whether they was complying with the Health and Social Care Regulations however these were ineffective. An internal inspection by the provider's compliance inspector in August provided an overview of the actions required by the home's staff and the provider to improve the quality of care. For example, the internal inspection noted the provider had not authorised the repairs of a hoist which had been broken for eight weeks, or a stand aid which had been broken and previously identified on the July 2017 audit as broken. The consequences of staff not having the right equipment might lead to poor moving people practice.

A number of staff during our inspection visit told us the provider was slow to agree to and provide funds for new initiatives. The quality improvement lead told us the provider was not slow, but it might be that staff did not know the right way to request change. They said that if done correctly, new equipment could be authorised on the same day.

Whilst the provider had a system of audits in place, they did not drive improvement for the benefit of people who lived at the home. The provider did not support the registered manager in making sure there were enough staff to meet people's needs. This was because we had identified this as a breach of the Regulation at our inspection in March 2017 and it had taken the provider until August 2017 to approve additional staff support for 11 hours a day. There was a high level of staff turnover, leading to increased use of agency staff and the resultant lack of continuity of care and lack of staff oversight for people who lived at the home.

Since our last inspection visit in March 2017, 13 care staff and one member of bank staff had left the provider's employment, and 21 care workers, three nurses, and one bank nurse had started employment. Staff turnover continued to be a major contributory factor in limiting the quality of care provided to people.

We asked whether an analysis had been undertaken to determine why staff kept leaving after a short period of time. The registered manager told us no analysis had been undertaken. However, their action plan following our previous inspection told us they would conduct exit interviews with staff and any themes would be reported back to the operations director of the organisation.

A relative told us, "They don't praise the staff up enough." They went on to say they had told one of the staff they were doing a good job. The staff member replied to them that no one had told them that before.

The registered manager was supported by commissioners of the service. They visited the home regularly to check the care provided to people was safe, and there were systems and processes to enable the registered manager to monitor the quality of care provided to people. They reported to us that whilst their advice was acted on at the time it was given, they found over time the same concerns were repeated as learning was often not consolidated or monitoring was not effective in identifying when gaps in service provision arose.

Staff at the home had mixed feelings about how they were managed and supported by senior staff. Care staff felt as care teams they worked well. But some care staff thought nursing staff and management were quick to blame them if anything went wrong.

Staff on the ground floor told us they were happier because the new clinical lead had made sure their rota's only allowed them to work four days in a row. This was important because of the long 12 hour shifts staff

worked. However, staff on the first floor said they were not happy with the way their rotas were managed. This was because the original rota was often changed by the deputy manager without consulting with staff first. This meant arrangements made for off duty times had to be cancelled, or if the member of staff did not know the shift pattern had changed, they did not turn up to work, and the shift was left uncovered by staff.

This meant the provider was still in breach of Regulation 17 of the Health and Social Care Regulations 2008 (Regulated Activities) 2014: Good Governance.

Care staff on the first floor, were very positive about the new clinical lead. They felt she was supportive of them, helped them with training, and listened to them. We saw the clinical lead work with care staff and saw why staff found her so helpful. She had a good understanding of people's needs and worked with care staff to help them understand how to support the person.

The registered manager had sent the required notifications to the CQC. Because they had undertaken this legal requirement we could see there was a significant number of safeguarding investigations at the home. The number sent to us was high enough for it be 'flagged' on our system as an 'elevated risk', because it was more than the average number of notifications for a home of its size.

After our inspection visit we liaised with the provider's new director for performance and regulation, the new quality director, and the new nominated individual for the home. They gave us re-assurances they would be acting swiftly on the concerns we had identified during our inspection to improve the quality of care provided. They sent us information outlining what action they had taken or were taking to respond to our concerns. This included not accepting any new admissions to the home until improvements were made in relation to the care provided to people who currently live there. They stated they would ensure comprehensive re assessments of people's care needs were undertaken should people look to return to the home following admission to hospital.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider continued to have a high turn-over of staff at the home. This meant not all staff had received the 'creative minds' training to support them with dementia care. The home had to use a high number of agency staff and this meant people with dementia were supported by staff they did not know well. There were not enough staff to support people with more person centred activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People reported to us examples of how their dignity was compromised by the actions and inactions of staff. We saw a member of staff not respecting a person's dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Identified risks related to people's health and well-being were not managed well to ensure people were protected from harm. People did not always have the right equipment, and accessible equipment to support their safety. Medicines were not always administered safely to protect people from harm. There were areas of the home and furnishings which were not clean.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs On our second visit to the home mealtimes were rushed. People at risk of malnutrition were not always receiving the additional food supplements they required. People who could not drink independently were not always getting enough fluid to keep them hydrated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had a complaints procedure, however many of the complaints had not been responded to in a timely way. Some people felt their concerns were not listened to and addressed by the registered manager.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not provided sufficient support to the registered manager or monitoring to improve the service. There had been limited improvements since our last visit but changes had mostly been reactive and in response to what other professionals had highlighted, instead of the provider and management team proactively identifying issues and making change happen.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels and staff deployment continued to not meet people's needs both day and night and on both the ground floor and first floor of the home.