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?	**Good**

Summary of findings

Overall summary

This inspection took place on 10 and 11 February 2016. The inspection was unannounced.

Coundon Manor is a nursing home which provides nursing care for a maximum of 74 people. The home provides care on two floors. People whose primary care need is dementia, are mainly supported on the ground floor, and people with more complex nursing needs are mainly supported on the first floor. Sixty five people were living at the home at the time of our inspection.

The home had a new registered manager. They were appointed in August 2015 and registered with us in January 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.

At our previous inspection on 1, 2 and 3 July 2015, we identified four breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of this inspection the home was put into special measures. We asked the provider to improve staffing arrangements; ensure people's individual and social needs were met; improve the cleanliness of the home; ensure people received the food and fluids required to maintain their health; and improve their quality assurance systems. The provider sent us an action plan and monthly updates to tell us about the improvements they had implemented.

During this inspection we checked improvements had been made. We found sufficient action had been taken in response to the breaches in regulations. However, there were some areas where further improvements were required. The provider had plans in place for on-going improvements to be made.

Overall, staff were available at the times people needed them. Since the last inspection staffing arrangements had been reviewed and additional staff were available to support people during busy periods. However, we had concerns that reduced staffing levels in the later afternoon and evening meant people might not have such a responsive service to their personal care needs as they did earlier in the day.

There had been significant improvements in the cleanliness of the home. An increase in housekeeping staff meant all areas of the home were clean and tidy.

There were improvements in meeting people's social and individual needs. An increase in the number of hours provided to support an individual and group activity programme had benefited people's social and emotional well-being.

In most cases, people received the food and fluids required to maintain their health. An increase in staffing to support meal times ensured that people who required assistance to eat, received the support necessary.

Due to their health needs, some people required additional snacks and drinks, but records did not always confirm they had been given.

The home worked well with the dietician, GP, speech and language team, and other healthcare professionals to support people with their healthcare needs.

There had been improvements in the personal care provided to people, however there were still instances when people did not receive the personal care they had requested or required.

At our last visit many people who could use a call bell to call for assistance, did not have one in reach. During this visit, most people's call bells were in reach and when people used them, staff responded quickly.

People and visitors were complimentary of the staff and the care provided at the home. We saw staff engaged well with people. People looked well presented with clean clothes and hair and people's privacy and dignity was promoted. Relatives and friends were able to visit the home at any time during the day or evening.

Complaints were responded to appropriately. The registered manager ensured all complaints, both formal and informal were logged centrally to identify any trends or themes and taken action when necessary.

The registered manager understood their responsibilities and the requirements of the Mental Capacity Act and the Deprivation of Liberty Safeguards (permission needs to be sought when a person who does not have capacity has their liberty restricted). However, not everyone had a documented best interest decision to provide information about why restrictions had been applied.

There were improvements in the management of the home. The provider had developed new processes to check the quality of care provided at Coundon Manor. The registered manager had worked hard to improve the standards in the home, recruit new staff, motivate existing staff, and promote an open and transparent culture.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

There were sufficient staff most of the time to meet the complex needs of people who lived at the home. There were a large number of new staff so there were occasions when people's needs were not always met. Staff understood how to safeguard people and minimise the risks to people when providing care. Staff recruitment procedures reduced the risks of the service employing unsuitable staff. Medicines were mostly managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff had received training, and this on occasion impacted on the way they cared for people. Most people were provided with food and fluids that met their needs, and people received input from healthcare professionals when required. Staff ensured they got the consent of people before they undertook any care, but not all staff understood the principles of the MCA and best interest decisions.

Is the service caring?

Good

The service was caring.

Staff were caring and kind to people. They understood how to support people's privacy and dignity. Visitors were welcome at any time.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People's personal care needs were not always met by staff in the way they preferred. Their social and emotional needs were now being supported by increased individual and group activities in the home. Informal and formal complaints were being investigated and actions taken when required.

Is the service well-led?

Good

The service was well-led.

The new registered manager and the provider had worked hard to improve the quality of care provided to people. The registered manager had an open and transparent approach to management, and morale in the home had improved.

Coundon Manor Care Home

Detailed findings

Background to this inspection

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

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This inspection took place on 10 and 11 February 2016, and was unannounced. The inspection team consisted of two inspectors, a specialist nursing advisor 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 we spoke with 14 people who used the service and seven relatives and friends. We spoke with 14 staff (this included the chef, housekeeping staff, care and nursing staff and activity workers) and spoke with the registered manager and the provider's operations director. We also spoke with a healthcare professional who was visiting the home.

We used the Short Observational Framework for Inspection (SOFI) at lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent significant time observing the care provided to people in the home throughout our visit.

Prior to our visit we received information about the home from the local authority commissioning team and the clinical commissioning group (CCG). Commissioners are people who work to find appropriate care and support services for people who do not pay privately. We also received information from two relatives. The registered manager had been sending us monthly updates about action they had taken to improve the service. After our visit we spoke with the community nutritional support dietician, a speech and language therapist, a social worker and two relatives.

We looked at seven care records, supplementary records (for personal care, and food and fluid intake), the shower records, medication administration records, quality assurance records, and records of internal inspections undertaken by senior management of the home.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 1, 2 and 3 July 2015, people with higher dependency care and support needs were not being met. This was because there was insufficient numbers of staff available to meet their needs and keep them safe. Insufficient staffing had also resulted in the home being dirty as there was not enough staff to undertake cleaning tasks. There were a significant number of staff vacancies which meant that agency staff and bank staff had to cover the rota on many occasions. This led to inconsistencies in the care provided. This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 - Staffing

Immediately after our last inspection, the provider increased the number of staff working on each floor of the home. They also sent us an action plan outlining how they would make improvements to their staffing arrangements.

During this inspection we found that, overall, improvements had been made in relation to staff being available at the times people needed them.

Previously people and staff told us the home was always short staffed with four or five care workers and two nurses working on each floor. Now, there were seven care staff, and two nurses who worked the early shift (7am to 2pm) on the first floor; and five care staff, and two nurses who worked the early shift on the ground floor. The number of care staff reduced by one on each floor for the late shift between 2pm and 7pm. A hostess on each floor supported people with meals and drinks from 8.30am until 3pm. There was a deputy nurse manager on each floor who was not counted into the staffing numbers and who could provide support to staff on the floor if needed.

The provider used the 'Rhys Hearn staff to person dependency tool' to identify the number of staff required to keep people safe and meet their needs. The registered manager told us the home was currently staffed above the recommended levels identified using the tool. We asked people and their relatives if they felt there was sufficient numbers of staff available to keep them safe. People and relatives who had been at the home at the time of our last inspection told us there had been improvements. For example one relative told us, "It has improved a hell of a lot since then (last inspection); there's more staff. They couldn't keep the staff before, but now it's definitely better." A person told us, "Some staff used to think I was swinging the lead when I said I needed help with feeding or going to the toilet, now they're good at talking to people."

At our last inspection, many people on the first floor were in their beds and not using the lounges. Staff told us this was because there were not enough of them to monitor or support people if they were in the communal areas. During this inspection we saw more people were out of bed, engaged in activities and using the lounge and dining facilities. A relative told us, "When she [person] first came here, no one would get her out of bed. Since the new manager has taken over and the new staff, she's taken out of bed, it is much better for her. They still have the odd time when it's not good, but generally it's a lot better."

However, there were still times when people did not get the staff support required to meet their needs. For example, one person said, "No I don't think there's enough, but this room is a bit isolated and I think they

forget about me." Another said, "One of the problems is that if you need anything, they're busy. I mean, my pad's wet. It's been wet for an hour." A relative told us, "I think they do their best. They could do with a bit more [staff] in the morning." During our visit we saw one person on the first floor had not received personal care and it was 11.30am.

Although the staff numbers had increased, the registered manager told us the first few months after the previous inspection were challenging because many existing staff left, and the provider had to recruit new care staff and nurses. This meant the use of agency staff continued longer than the provider had hoped for, and continuity of care continued to be an issue. However, this was now mostly resolved.

The registered manager told us since September 2015 they had recruited 45 new staff. They told us all the staff who supported people on the first floor, had been recruited since our last inspection. The registered manager felt they had 'turned a corner' and whilst they occasionally had to use agency staff to cover staff sickness, the staffing levels were sufficient. However, they acknowledged that many of their staff were still new to working at the home. This meant they sometimes took longer to provide care because they did not know the needs of people as well as more experienced staff.

We spoke with staff who had also worked at Coundon Manor during our last inspection. One member of staff told us the recruitment of new staff had brought about stability in the staff group. They told us previously, that when staff arrived for their shift they had not known which area of the home they would be working. Now, staff mostly worked on one floor of the home and they felt this supported continuity of care for the people who lived there. They also told us that having a deputy manager on each floor helped them provide prompt support and better decision making.

During our last inspection people told us that staff deliberately made sure they could not reach call bells. At this inspection we checked that call bells were in easy reach for people. Whilst most call bells were available to people, we saw some occasions when they were not. For example, the person who told us their pad was wet, was not able to call for staff assistance because their call bell was draped over the arm of the armchair and out of reach. When we gave the person the call bell to use, staff came quickly to support them. Another person who was in some discomfort and pain had their call bell stuck between the bed mattress and bedrail. Again, when we gave them the call bell and they pressed it for assistance, the staff came quickly. We informed the registered manager. They told us they would look into why people did not have their call bells available as they should. A person told us "In the old regime, they used to switch off the call system but now, you might only have to wait a few minutes."

Risks related to people's care needs were identified and mostly managed safely. For example, staff looked at the risks people had associated with weight loss, incontinence and skin care. We looked at the care records of four people. Risk assessments were updated regularly to ensure any new risks were identified and acted upon. The service had the equipment necessary to keep people safe. For example, people at risk of skin damage had pressure relieving cushions and mattresses which reduced the risk of pressure sores developing.

However, two relatives voiced concerns that continence pads were still not always being changed within the four hour period detailed in a person's care plan. This meant the risks of people's skin becoming damaged as well as them feeling uncomfortable were increased. We randomly sampled four care records for the first week in February 2016, and went through the records with one of the deputy managers. Two of the care records showed there were periods of time when people were not having their continence pads changed every four hours in accordance with their care plans. For example, one person's record showed their pad was changed on 3 February 2016 at 8.35am and then again at 4.18pm; and on 4 February there were two

periods where they had to wait over five hours for their pad to be changed. We discussed this with the deputy manager who told us the care staff were responsible for completing the records to demonstrate pads had been changed, and they therefore could not confirm whether the care had been provided as planned.

At our last inspection we found many areas of the home were dirty. Immediately after our visit, the provider put actions in place to improve the levels of cleanliness in the home. This included bringing in staff from other homes within the provider group to undertake a 'deep clean' of the home and recruiting new housekeeping staff. A person told us, "They never used to clean the room at all. They now come in every day." We spoke with two of the housekeeping staff we had spoken with at our previous inspection. They told us there were now enough housekeeping staff to keep the home clean. One said, "I used to dread coming to work, but I don't now." We saw all areas of the home were clean and tidy. A relative who had also visited the home prior to our previous inspection told us, "Cleanliness is now absolutely superb." Another told us, "There have been some improvements. Cleaning is much better."

People told us they felt safe. One person said, "Oh yes, I do feel safe. The staff are kind." A relative said, "Yes, I think [person's] safe. I come here every day." Staff understood their responsibilities to keep people safe. Staff told us they had received training in protecting adults from abuse and knew how to raise concerns. They understood the different types of abuse and how to recognise them. Staff told us what action they should take if any form of abuse was suspected. The registered manager was aware of their responsibilities to report concerns to the local authority safeguarding team, and had notified any safeguarding concerns to us at the CQC. The number of safeguarding concerns had reduced significantly since our last inspection.

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

The provider had policies and procedures for managing risks to people so they were protected from harm. There was a security code on the doors to protect people from unwanted people entering the building and those people identified as at risk when leaving the building on their own. Each person had a personal emergency evacuation plan to help staff know how to evacuate the person in the event of an emergency. The provider had a contingency plan which gave staff instructions about what to do to keep people safe, and who to contact in the event of unforeseen circumstances such as loss of power, loss of water supply and serious outbreaks of infection. During our inspection a water pipe in the hairdressing salon burst, which meant the water for the home had to be turned off for a period of time. This was dealt with well and minimised disruption to people who lived at the home.

The provider undertook monthly reviews of accidents, incidents and pressure sores. Where incidents had occurred, these had been investigated and action taken to reduce the risk of them happening again.

People told us they had their medicines when they needed them. One person told us, "My medications used to be maybe two or three hours late, but it's important for my condition that I have them on time. They're more conscientious now. They make sure that medicines are on time and they take time to make sure you've taken your pills." However, we saw that a letter written by a specialist nurse to the home dated 16 January 2016 had advised the times of this person's medication be changed from 8pm to 6pm and this had not happened.

We checked the administration of medicines to see if they were managed safely and whether people received the medicines prescribed to them. We observed medicines being given to people. The nurses ensured the medicine trolley was locked for safety each time it was unattended, and personally ensured each person had taken their medicines before attending to the next person. We checked that staff were accurately recording medicines given. Most medicines were recorded correctly on the medicine administration records (MARs), however on one occasion we saw a controlled medicine had not been signed by two members of staff to confirm it had been given. Because of the strength of controlled medicines, it is considered good practice to have two staff sign for this medicine to ensure the medicine had been administered correctly and safely.

Care staff administered prescribed skin creams. Where it had been assessed as safe, these were kept in people's bedrooms. Staff signed charts to confirm that creams had been applied as required. Each person's record included a body map to show staff where the cream should be applied to ensure the cream was applied in the correct place.

We looked at medicines prescribed on an 'as required' basis. We saw medicine plans which explained why the person might need this medicine, and staff recorded on the MAR when and why it had been given. However, we found some inconsistencies in how staff recorded 'as required' medicines were offered or administered. This meant it was not always clear why the person had or had not received their medicine.

People who had their medicines given in disguise (covertly) had been assessed as not having the capacity to make an informed decision to refuse their medicines. A meeting with the relevant people had taken place, and the outcome documented as to why it was in their best interest to receive the medicine. Some medicines had been discontinued because it had been considered that they were not crucial for the person's health to continue taking them.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 1, 2 and 3 July 2015, people with higher dependency care and support needs were not receiving the food and fluids they needed to maintain their health. This was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010: Meeting nutritional needs. The provider sent us an action plan outlining the improvements they would make.

Since that visit, the provider introduced a 'hostess' system. From 8.30am to 3.00pm a 'hostess' on each floor helped the care staff by providing additional support to people with drinks and snacks, and supported people to eat their meals. Care staff told us this had helped them ensure people received the food and drink they needed. We also saw one of the dining rooms which had not been used at our last inspection, was now in use. The registered manager told us that sitting in the company of others to eat their meals encouraged people to eat and drink more.

Most people told us they liked and enjoyed the food. They said, "The food is nice, tasty." Another said, "The food is nice. There's always plenty to drink. We've just had a nice cup of tea and a biscuit." They told us they always had choices and were able to eat the things they liked. On the day of our visit, most people were seen eating well and finished most of the food on their plate.

The chef was aware of people's nutritional needs. They were informed by the nursing staff which people were under weight or overweight. For people who needed to gain weight, they fortified their foods with cream and butter to increase the energy and nutrient content. Nursing staff also made the chef aware of people who were on other specific diets such as soft food diets, vegetarian, halal, and diabetic diets. We saw these had been provided to people.

Drinks were regularly available to people throughout the day at set times, but not always when people requested them. The introduction of the hostess role meant that people could be assured at certain times of the day there would be drinks made available. However, a person on the first floor was thirsty and asked a care worker if they could have a drink. Instead of making the person a drink when they wanted one, the care worker told them the tea trolley would be with them soon. Most drinks provided were in reach of people, but there were a couple of occasions when drinks had been placed out of reach of the person.

People's weights were checked and their risk of malnutrition assessed. Referrals were made to the dietician if they were assessed as needing professional input. Food and fluid charts were implemented to monitor whether the person was receiving the right food, drinks, care and support to gain weight. We spoke with the dietician about how the home's staff supported people who were at risk of losing weight. They told us they had seen improvements in the support given to people, and food records documented the main meals people had eaten. However, there were still concerns that fluids and foods such as snacks between meals and after 6pm were not being recorded. These records would assist the home to be sure people were receiving the extra foods and fluids to meet their dietary needs, and would assist the dietician in their assessment of people's needs.

We spoke with the speech and language therapist who supported the home. They told us the staff were making appropriate referrals to the team. They said that some staff at the home had undertaken training with them, and were "in a much better place" to understand their advice. Staff who had completed the training also had a heightened awareness of when a person was at risk of dysphasia (problems with swallowing or choking).

Staff reported people's weight loss to their GP. The advanced nursing practitioner who attended the home on behalf of the GP surgery told us that the quality of information provided by the home's staff for issues such as weight loss had improved. They told us that staff now gave more detailed information about the weight loss to help them and the GP understand what the issue was in advance of a visit.

People's health care needs were well-documented in care plans. People had been referred to a range of external professionals including the GP, speech and language therapists, community psychiatric nurses, dietician, and specialist nurse advisors for diabetes. A relative told us their family member had been in hospital for three months before they came to Coundon Manor. They told us the person's toe nails had not been cut, but since coming to the home, "A chiropodist was called within a few days, the hairdresser was with her within days. I asked about a dentist, because of trouble with her teeth and one was called. The GP was called last week due to a swollen hand…it is excellent here, people have good care. I am delighted with the staff and the home."

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.

We checked whether the provider was working within the principles of the MCA. There were mixed responses from staff about their understanding of the MCA. Some had received training on the Act and demonstrated to us their knowledge and understanding of the processes for assessment. Others had little understanding and had not received training.

We saw capacity assessments had been undertaken by staff. Some were very clear and decision specific, such as when people required medicines to be taken in disguise. Other assessments informed that a person did not have capacity, but then did not go on to inform about how this impacted on their decision making. For example, one person smoked cigarettes. They were not mobile and relied on staff to take them outside the building for a cigarette. Staff told us that due to pressures of staff time, they were only able to take the person outside three times a day. We heard the person continuously ask to go out for a smoke. There was no decision specific capacity assessment to determine whether the person had the capacity to understand the risks of smoking as many as they wished; and if so, to exercise their right to make this decision. We could not see in the care record any best interest meeting to look at how the person's smoking could be managed in their best interest and with least restrictive practice. The deputy manager told us they would make sure a best interest decision was taken and recorded.

A social worker informed us they had concerns about capacity assessments related to two people they had worked with. Both people had been assessed by them as having capacity to make decisions, however the home's mental capacity assessments had informed that they did not. We had spoken with one of the people they referred to, who had full capacity. The social worker told us the registered manager had acted on this information and made sure the people were re-assessed. This meant that staff who undertook the original assessments did not have a clear understanding of the Act and how to apply it in practice.

The registered manager understood their legal responsibilities to apply for Deprivation of Liberty Safeguards for people who did not have capacity and whose freedom of movement had been restricted. DoLS applications had been made to the local authority for all people whose freedom of movement had been restricted.

Not all staff had received all the training the provider considered essential to meet people's health and social care needs. The registered manager told us they had not been able to complete all the required training because so many new staff had started. They explained that all staff had undertaken training such as fire training, and 'moving people' training, but they had struggled to find time for staff to take part in other training as there had not been enough staff to cover shifts. The provider had acted on this, and agreed for a trainer to work at the home to ensure all staff had received the required training by 1 April 2016. Staff from other homes in the provider group, were going to be brought in to cover shifts so staff would be available to attend the training. All new staff had however started the Care Certificate. The Care Certificate is an identified set of standards for health and social care workers. It sets the standard for the skills, knowledge, values and behaviours expected.

On the second day of our inspection we met with the member of staff who was going to deliver the training. They confirmed they would also be supporting staff to understand the MCA and provide them with training in dementia awareness. We saw a training plan which demonstrated that MCA and DoLs training was starting on 19 February 2016. The registered manager also told us a member of the local authority DoLs team was coming to discuss DoLs applications to further develop staff understanding of this.

We saw that staff had put their training into practice. For example, we observed one person being moved by a hoist. We saw staff spoke with the person and re-assured them during the time they were hoisted and distracted them from their anxiety about being moved. A new member of staff, who had worked at several other care locations, told us the moving and handling course, "Was a full day course, it was the best I have ever been on. I learned a lot about moving techniques, including better use of slide sheets and how to roll people more effectively when moving."

However, we saw two instances where new staff did not appear to know how to respond appropriately to people with dementia. For example, a person wanted to look at the food on the hot trolley before it was served. The care worker, aware that the trolley was hot, told the person, "The trolley is very hot, come and sit down." This made the person angry and they raised their voice because they felt they were being denied the chance of looking at the food. In turn, the staff member spoke sharply with them. On another occasion, a person was assisted to eat lunch. The person had their eyes closed throughout and kept putting their arms up in front of their face. The staff member appeared to get frustrated with this, and said, "Keep your hands down. Put your hands down…put your hands down. I've got you some dinner."

Staff who had worked at the home in September 2015 had received specialist training in dementia care with a dementia coach who attended the home for six days. The registered manager told us they hoped to provide this to all staff who started work after September 2015, but because 50% of staff who received the training, still worked in the home, this training would be scheduled at a later date. New staff members were receiving dementia awareness training to support them in their understanding of dementia care.

Good

Is the service caring?

Our findings

People and their relatives mostly told us that staff were kind and caring. One person told us, "I like the staff, they are good to me." Another person told us, "Oh yes, they are very helpful, they are smashing." A person who was at the home for respite care (short stay) told us they would recommend Coundon Manor to anyone. A relative told us about their family member who lived at the home and said, "They don't treat her like a child, they talk to her and listen to her."

During our inspection, we saw staff spent time with people when they could. Staff sat with people in the communal areas, and engaged well with people. Some people were unable to communicate verbally, but staff knew how to relate to them and get positive responses. For example, a person without verbal communication had their own specialist chair near the entrance area where they could see people passing. All staff spoke with them as they passed. The person appeared to enjoy sitting there because of the social interaction, as we saw they interacted with staff and other people as they went by.

We saw staff were considerate to people's needs, and made it clear that the person mattered to them. For example, a member of staff when encouraging a person to eat said, "[person's name], are you sure you don't want anything to eat, would you like to try some in a little while?" Another person informed a member of staff as they supported them to go to the dining room, "I don't know where I am." The member of staff said gently, "You're at home, in Coundon Manor, I'm going to look after you," They then continued supporting the person with their walking, saying, "That's it, take your time." In response to the member of staff, the person smiled and appeared to relax.

Staff spoke with interest and affection about people. A staff member said that sometimes they were short staffed, but could provide the care people needed. They explained, "Sometimes residents say hello as you pass them. What they are really saying is, I want you to come and talk to me. That is what we usually do, but sometimes we have to say, I have to go now but will come back later. We feel bad or guilty about having to leave them."

The registered manager had started to involve people more in the day to day planning of their care. Previously the home had a 'resident of the day' system, which meant one day each month, each person and/or their representative met with designated staff at the home who checked whether they were receiving care in the way they wanted. The meeting covered all aspects of the person's daily care needs and included housekeeping staff and the chef. This initiative had been put on hold while the registered manager dealt with the staffing issues, but had recently started again.

Staff gave us examples of how people's dignity and privacy were respected and promoted. For example, they told us they would ensure people received personal care in private, and would cover exposed body parts to ensure people's dignity was maintained. We observed examples of this during our inspection. For example, one person required moving from a chair in their bedroom to their wheelchair. Staff shut the door to their bedroom to carry out this move. A person told us, "I would say something if they weren't respectful of me. It's important."

At our last visit we saw people' dignity was compromised because they were not offered something to cover their clothes when they ate, and people sat in clothes covered in food debris for long periods of time. During this visit, people were offered protective coverings for their clothes, and people looked clean and appropriately dressed throughout the day. We also saw some of the women who lived at the home had recently had their hair done. People's nails were cut, and some women had their nails manicured and painted.

At our previous inspection, staff were not employed to work on a specific floor. This meant people who lived with dementia did not receive care and support from staff who were familiar with them. The registered manager had changed this approach. Staff now worked on the floor that matched their skills and experience, and matched them with the needs of the people who lived at the home. They also worked a specific section of the floor which meant they could learn more about the people they supported and better understand their individual needs.

Staff who had worked at the home at the time of our last inspection told us they now felt more cared for by the provider and were much happier about coming to work. They told us morale had improved.

There were no restrictions in visiting times for friends and relatives of people at Coundon Manor. During our inspection we saw many relatives arrive and spend time with their family members.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 1,2 and 3 July 2015, care was task focused and not focused on the needs of each person. This meant individual needs had either not been identified or acted on. People's social care needs were not met because staff did not have the time to provide interests or activities for all. The home was in breach of Regulation 9 HSCA (RA) Regulations 2014 Person-centred care. At this inspection we checked to see if improvements had been made.

Many of the people who lived at Coundon Manor could not speak for themselves and relied on their relatives to act as their advocates and to provide information about their needs. At our last inspection, relatives told us they were not involved in the pre-admission assessments, or subsequent discussions about their family member. During this inspection we spoke with relatives of people who had recently been admitted. Each person had a pre-admission assessment to determine what their needs were and how staff could support them with this. A relative of a person who had been admitted six weeks before our visit told us, "I was involved and gave information prior to [person] coming here. They gave me a copy of the care plan and asked my views. A review was held 10 days ago here at the home. I was invited and able to say how I felt about the care, they were interested in my views. I felt part of the process." Another said, "We came and looked here and another home. We had a meeting with the manager. Up until now we have been very pleased as staff have been very pleasant and helpful."

Other relatives we spoke with confirmed they had been involved in reviews of their relation's care. One relative said they had recently had a review with one of the nurses which they said was "Useful". They told us as a consequence of the review, other healthcare professionals were now involved in their relative's care.

At our last inspection on 1, 2 and 3 July 2015, care was task focused and not focused on the needs of each person. This meant people's individual needs had either not been identified or acted on. People's social care needs were not met because staff did not have the time to provide interests or activities for all. This was a breach of Regulation 9 HSCA (RA) Regulations 2014 Person-centred care. The provider sent us an action plan outlining the improvements they would make.

Many of the people who lived at Coundon Manor could not speak for themselves and relied on their relatives to act as their advocates and to provide information about their needs. At our last inspection, relatives told us they were not involved in the pre-admission assessments, or subsequent discussions about their family member.
During this inspection we spoke with relatives of people who had recently come to live at the home.. A pre-admission assessment had been completed for each person to determine what their needs were and how staff could support them with this. A relative of a person who had recently come to live at the home told us, "I was involved and gave information prior to [person] coming here. They gave me a copy of the care plan and asked my views. A review was held 10 days ago here at the home. I was invited and able to say how I felt about the care, they were interested in my views. I felt part of the process." Another said, "We came and looked here and another home. We had a meeting with the manager. Up until now we have been very pleased as staff have been very pleasant and helpful." However, one visitor we spoke with told us their

relative had been at the home for a few weeks and nobody had spoke with them about the person's care needs. Another relative told us their family member had lived at the home for several weeks and they had not been involved in any care planning.

Other relatives we spoke with confirmed they had been involved in reviews of people's care. One relative said they had recently had a review with one of the nurses which they said was "Useful". They told us as a consequence of the review, other healthcare professionals were now involved in their relative's care.

At our last inspection we were concerned that people did not receive personal care such as washes, teeth cleaning and showers when they wanted to. We checked again at this inspection. We looked at a selection of daily charts and found people usually received a wash and mouth care in the morning, however there continued to be gaps in the records for the afternoon and evening. This suggested that people did not always receive a wash or assistance with mouth care before going to bed at night. For example, one person's care plan asked that staff rinse the person's mouth daily. Records for one week indicated there were two days when this had not happened. Because of the person's health condition, they were not able to tell us whether they had received this care.

At our last inspection we were told people normally had one shower a week. We were concerned whether this frequency ensured that people's personal hygiene was maintained. We also had concerns this did not meet people's individual showering/bathing preferences. We checked at this inspection to see whether this had improved. There were still times when people were not receiving the showers or baths they wanted. One relative told us they had requested their family member have a shower every day, and in the previous week, they had only received two showers. We checked four care records and they all indicated that no-one had received more than one bath or shower in a seven day period, and one person had to wait eight days between their bath and shower.

During the late afternoon and evening, there was a reduction in staff. We were concerned that the reduction in staff might impact on the responsiveness of staff to undertake care and this was why there were gaps and omissions in the care records. We spoke with the registered manager about this, who agreed to monitor and take action if required.

One person, who did not have capacity to make their own decisions, had a care plan which clearly stated they would like at least two showers a week. However, when we spoke with the nurse, they informed us the person's behaviour indicated they 'hated having a shower' and sometimes refused to have one. They told us the person's behaviour suggested they preferred to have a bed bath, and instead of showering, staff would support them to have a bed bath. Their preferences had not been documented in their care plan, and there had been no decision taken in their best interest to provide personal care via a bed bath. The nurse updated their care plan during our inspection.

Care records were reviewed monthly, and any changes to people's care needs were communicated to staff through meetings at the start and end of each shift (handover). All care and nursing staff were involved in the handover meetings to ensure they understood people's changing needs.

At our last inspection the provider had employed an activity worker to work at the home seven days a week. One activity worker was responsible, each day, for meeting the social needs of up to 74 people who lived at the home. We had identified there was insufficient time available for them to support people who were not able to undertake group activities.

During this visit we saw that the number of hours for activity support had increased. There were now two

activity workers who arranged and supported people with group and individual activities each day, including the week-end. In the morning of our inspection, we saw an organised skittles activity with people from each floor competing with each other. Much laughter was heard during this activity and it was a talking point at lunch time in the ground floor dining area. In the afternoon, a petting dog came to the home for people to stroke and to enjoy. A relative told us, "There are more activities than there ever were, and they are taking residents to the activities. Previously the activity was finished by the time people were got out of bed." A person told us, "Things have got a lot better. We have entertainment a couple of times a week. We have singers and exercise classes."

The activity worker we spoke with told us they had events arranged until the early summer. The home now had a minibus and they could take up to six people on trips outside the home. They had also involved relatives to help make 'twiddle muffs' (a knitted muff with items attached so that a person who lived with dementia had visual and tactile stimulation), and had asked relatives to help them get to know people's backgrounds by completing a 'life history' of the person. The provider had purchased a reminiscence newspaper which people had access to each day. The activities worker told us that one of the people who lived at the home enjoyed reading this for themselves and read it to other people in the home as well.

Each activity worker had a designated floor of the home, and this meant they were building up knowledge of the people who lived on that floor to be able to provide activities and interests which met their needs. The activities worker said they also spent individual time with people who chose not to engage in group activities. A relative told us, "Staff have spent time with [person] in her bedroom, just chatting and painting her nails."

The provider had a complaints policy and procedure which people and their relatives were aware of. We saw formal complaints were addressed by the registered manager in accordance with the policy. At our previous inspection, the outcome of informal complaints was written up in the person's care file. This meant the provider and registered manager could not identify whether there were any themes or trends in complaints made to staff. The registered manager now recorded all complaints in a log book, and checked to see if there were emerging themes, so that actions could be taken to address these.

The registered manager had arranged meetings with relatives to explain to them how they would be moving the home forward, and to listen to their concerns. The meetings had taken place approximately every two months, and the registered manager had met individually with relatives who had expressed concerns. A relative told us, "They've held meetings for residents, families and friends letting us know there was somebody out there and what their plans were."

Good

Is the service well-led?

Our findings

At our last inspection we had concerns that the provider's quality assurance systems did not assure that the home was providing safe and good quality care. This was a breach of Regulation 17 HSCA (RA) Regulations 2014. Good Governance. The provider sent us an action plan outlining the improvements they would make. Since our last inspection, the registered manager had left their employment at the service and a new manager was recruited and registered with the CQC. They started working at the home in August 2015, and had been working at the home for six months at the time of our inspection.

The registered manager and provider had worked hard to improve the service since it went into special measures. We met with the provider a week after our previous inspection and they had already put in place an action plan to improve the service. As further information about improvements required to the service they provided became available to them, this was also added to the action plan. The provider and registered manager were open and transparent about the challenges they faced and the improvements they had made. The registered manager was in regular contact with the CQC and other commissioners of services to inform them of developments in the home. The provider had regularly visited the home to speak with people and their relatives, to listen and respond to their views about the service and the care provided.

The provider has a legal requirement to inform the public of the home's rating. They had informed the public on their website that they had been rated as overall 'inadequate', and a poster with their ratings was displayed in the reception area of the home. Alongside the poster, the provider had informed people and their relatives of actions they were taking to improve the service.

The provider informed us they had learned lessons from our last inspection and had changed their processes and their own quality monitoring systems. We saw there had been a number of internal quality monitoring inspections carried out by the provider. For example, monthly audits were completed and the Operations Director continued to make monthly monitoring visits. These included checks to ensure appropriate action had been taken with people who had weight loss, skin damage, and incidents and accidents. We noted at our visit that the lighting in the corridors was dim and it could make it difficult for people to see. We found this had been identified in a recent audit and the provider was obtaining quotes to improve the lighting. They had also found gaps in the bedrails, and had ordered new wedges and bumpers to protect people's safety.

We asked people and relatives if they had seen improvements in the quality of people's care. A relative told us they were pleased with the staffing levels and felt they had made a difference to their family member's care. They were concerned however; that if the home got the 'green light' at inspection that the provider would reduce numbers again. We informed the registered manager and operations manager of this person's concerns. They assured us this would not happen and improvements made to service provision would be maintained.

Another relative, whose family member had also lived at the home during our last inspection, told us, "Since [the registered manager] has been here, it is much better; she is doing her best to make improvements."

Another relative commented on how the morale of staff seemed to have changed for the better.

Whilst all relatives we spoke with had seen some improvements, some felt further improvements were required. The registered manager acknowledged they still had work to do to further improve people's care, and would continue to strive to improve the quality of care provided. They told us they had been given, "110% support by the provider to improve standards." For example, they were now supported by two nurse deputy managers who were not part of the staff rota to provide nursing care. This meant as a management team they had sufficient time to support staff in improving standards of care.

At our last inspection staff told us morale within the staff group was low, and they did not feel listened to. At this inspection, the staff we spoke with felt the management team were supportive of them. One member of staff said, "The manager is always out on the floor. Everyone is happy, we work as a team." Another told us, "There have been changes and things needed to change. There was a negative atmosphere. There are new staff and the culture has changed. The standard of care has improved, we enjoy our work more [registered manager] has made the difference, she is always around, we can speak to her about anything, as we can with the senior staff." Previously staff had told us that management supervision sessions with them were only held to inform them if they had done something wrong. The registered manager told us that they saw supervision as a supportive tool for staff, not to performance manage staff.

The registered manager has a legal obligation to notify us of any incidents, accidents or deaths which occur at the home. They were meeting their legal requirements.