Amore Elderly Care Limited

Coundon Manor Care Home

Inspection report

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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?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place in the evening of 1 July 2015, and during the day on 2 and 3 July 2015. The inspection was unannounced. We carried out this inspection during the evening and daytime because of concerns raised by members of the public and staff about the level of care provided at the home.

Coundon Manor is a large 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. Seventy three people were living at the home at the time of our inspection.

The home has 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.

There were not enough staff to meet people's health and social care needs. The provider was trying to fill the gaps in the planned staff rota with agency and bank staff. The use of agency and bank staff to cover staff vacancies meant people were not provided with continuity of care by people who knew them well. The 'staffing tool' used by

Summary of findings

the provider to determine the number of staff required; did not provide sufficient staff to meet the needs of people, or take account of the size and layout of the building.

Staff were kind and most of them were attentive to people when they provided personal care. However, staff interaction with people was mostly when supporting people with care tasks. We saw little involvement between staff and people at any other time of the day. There were limited opportunities for people to be involved in social activities, particularly people with high dependency needs.

People who were independent received food and fluids which met their nutritional and hydration needs. People who were dependent on staff helping them with food and fluids did not always receive the support they needed to eat and drink. Drinks were not always placed in people's reach. Staff did not always provide people with protective covers when eating, and people were left to sit in dirty clothes for the remainder of the day which compromised their dignity.

The personal care provided did not always meet people's preferences or expectations. Most people only received a shower once a week and records showed that many were not supported to have a wash at night or their teeth cleaned. Care provided was task orientated and not tailored to the needs of each individual (person centred care).

There were numerous areas of the home that were not clean. Food debris or stains were found on chairs, equipment, carpets, tables and beds.

Call bells were not always in reach of people who could use them. At times people's needs were not noticed because they were not able to ring for help. Those who did, received help promptly.

Care records identified risks relating to people's care but staff had not always acted on the risks.

The registered manager had responded appropriately to formal complaints. However, some staff and relatives had raised a number of informal complaints and concerns, some of which they felt had not been adequately addressed. This information was contained in people's care files and in staff files, but had not been used by the registered manager to identify and act on patterns of concern.

Relatives and friends were able to visit the home at any time in the day or evening.

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, consent was not always gained from people who had capacity when their freedom was restricted.

There were mixed views from staff as to whether there was an open and transparent management culture. Quality assurance management systems had not identified the concerns we raised at the inspection. We had concerns that the home had a history of non-compliance with the regulations, and the concerns raised at this visit were similar to concerns raised in other inspections in the last few years.

The overall rating for this service is 'Inadequate' and the service is therefore 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

Summary of findings

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe

There were not enough staff to meet the complex needs of people who lived at the home. People were not provided with continuity of care because staff had left, and vacancies were being filled by bank and agency staff.

Risks were not always appropriately managed, and parts of the home were dirty.

Inadequate

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

People with high dependency needs did not always get the support they required to have sufficient food and fluids. Staff received training to enable them to provide effective care, but there were insufficient staff to put the training into practice. Not all staff felt they had effective support and supervision.

Requires improvement

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

Care staff were mostly kind, and wanted to provide good care to people, but the number and deployment of staff meant care was task focused and not focused on the individual. People's dignity was not always maintained.

Requires improvement

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

People were given limited opportunities to follow interests or be involved in social activities. Personal care was not responsive to people's individual likes and dislikes. The provider had investigated formal complaints according to their policy and procedures. However informal concerns or complaints were not logged to identify whether underlying trends or issues needed addressing.

Requires improvement

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

Many staff felt leadership within the home needed improvement. They did not feel listened to, and the management team was not visible at all levels or empowering. Quality assurance systems had not been effective in identifying and acting on issues impacting on the quality of care provided.

Inadequate

Coundon Manor Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 1, 2 and 3 July 2015, and was unannounced. The inspection team consisted of four inspectors. We visited the home because of concerns raised by members of the public and staff about the quality of care provided to people who lived at Coundon Manor. Prior to our inspection we also reviewed safeguarding information, and notifications sent to us by the registered manager.

During our visit we spoke with five people who used the service, and 17 relatives and friends. We spoke with 20 staff (this included domestic, care and nursing staff and activity workers) and spoke with the provider's management team in 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. We wanted to find out what life was like at the home in the later evening and so on 1 July 2015 we were at the home from 8.45pm to midnight.

Prior to our visit we received information about the home from the local authority contracts monitoring team, the CCG and the community nutritional support dietician. After our visit we received information from two more relatives about the care their relations received.

We looked at seven care records, a minimum of nine supplementary records (for personal care, food and fluid intake) on both floors, the shower and weight records, staff rotas and clocking in sheets, quality assurance records, and records of internal inspections undertaken by senior management of the home.

Inadequate

Is the service safe?

Our findings

Prior to our visit, a number of staff and relatives contacted us with concerns that there were insufficient staff to provide safe care to people who lived at Coundon Manor

On the first day of our inspection, we visited the home at 8.45pm to observe care provided at that time and so we could speak with the night staff. We stayed at the home until midnight. The shift ran smoothly during the time we were there. Most staff told us that as long as the staffing level of three care staff and one nurse on each floor was met, there were sufficient staff to meet people's needs during the night. One staff member said, "I've never had a problem on nights, unless someone hasn't turned up." Another said, "I don't feel residents suffer, but it would be helpful to have another staff member."

The many relatives we spoke with told us there were not enough staff to support people's care safely. One relative told us, "There is never enough people, never enough staff." Another said, "The two girls [staff] looking after entertainment, they are often pulled in to do the caring." A third said, "We make sure someone comes in every day because we don't trust the care will be given."

Whilst some staff told us the levels of staffing were sufficient to meet people's needs, most of the day staff we spoke with, had concerns about staffing levels. They told us staff absences were not always covered which meant they were not always available at the times people needed them. They told us, "We're always short staffed, it is normally four or five carers (the fifth staff member works across both floors of the home), If we get six we are lucky – today we are lucky."

Some staff and relatives told us the staffing levels on the day of our visit were better than usual. One staff member said, "When you are here then it is magically fully staffed." A relative contacted us after the visit to share the same experience. They told us, "The staffing on Thursday was nowhere like it usually is; it was like being in a different place." The operations manager confirmed there was an additional member of staff on duty on Thursday morning, because a member of staff on the later shift had mistakenly come in to work the early shift.

The registered manager told us they thought the staffing levels were sufficient and reflected the dependencies of people who lived at the home. They told us a number of staff had recently left and they were using agency (staff employed by a nursing agency to work in different nursing homes) and bank staff (staff employed by the provider to provide additional cover when there are staff absences) to support people's care needs until new staff were recruited and inducted. The manager told us they ensured the identified staffing levels were met on each shift. Some relatives and staff did not agree; they informed us their experience was, there were not always enough staff to deliver care and support safely.

We asked the provider's operations manager to check whether the number of hours worked by staff reflected the number of staff identified by the provider's staffing tool as required to support the dependencies of people in the home. They sent us a breakdown of staff hours worked. This showed that on the whole, the rota reflected the assessed dependency levels. This meant there should be six care staff and two nurses on duty on each floor during the day, and not seven care staff as some staff thought there should be.

On the days of our visit the home was fully staffed according to the provider's staff to person, dependency tool. However, we spent time observing staff and found there were insufficient staff to fully meet the complex care needs of people who lived at Coundon Manor, particularly on the first floor where there were more people with higher dependency. Some people were still having their morning washes at 12.30pm. One person told us, "I got up at 7am. I want to be washed and dressed." We looked at the time; it was 10.35am and they were still not dressed. Another person said to us, "I should have been out of bed and in the chair an hour ago. I would like to be out of bed."

Some people's relatives told us their care needs were not being met because staff were not available at the times they needed them. For example, one person's relative said, "Often [person] is left in a wet pad. They are not checked often enough." Another told us, "Mum is often left in a personal mess and becomes agitated. Because the staff follow a rota pattern for changing and tell us they have to do this, we often change and clean our mother. It takes less than five minutes." Another said they had asked for their relation to be up and dressed ready for them as they were coming with other visitors. When they arrived the person was wet in bed with no clothes on.

We looked at people's care records. These showed when a continence pad had been checked and when they had

been changed. We were told most people had their pads changed every four hours. On one chart, a person's pad had been recorded as being changed at 11.25am, and then there was no record to show the person had been checked or changed until 21.30pm. Another record identified that a person had their pad changed at 16.50pm and then not checked and changed until 11.20pm. This meant there were times people were not having pads changed or checked and this could put people at risk of skin irritation or skin breakdown. We asked staff whether they had time to change people's continence pads at the required frequency. One member of staff told us, "It can sometimes be quite difficult. Today it is fine because there are seven [staff] but normally it is a rush and it's constantly one and then another, it is a rush to get it all done."

When staff were busy in people's rooms undertaking personal care, there were occasions when there were no staff available to monitor the safety and whereabouts of people who were mobilising elsewhere in the home. We observed a person who lived at the home, walked uninvited into another person's bedroom.This person was clearly in distress, their face was contorted and they were waving their arms frantically to signal they did not want this person in their room. The person left and we made sure the other person was safe. A relative told us, "Residents wander into different rooms, sit on beds and soil the bedding or leave a mess all over the floor when using the room as toilets; bathrooms often have piles of excrement in the corners."

On the first floor, we saw one person was sitting in a wheelchair next to the nursing station. Nursing staff told us the person was sitting there so they could make sure they did not fall. Apart from whilst in bed, we saw this person sat in a corridor by the nurses' station for the majority of the time we were at the home. We were told by visitors this person was there for long periods of time each day. The person's care plan stated the person needed to spend time near the nurses' station to minimise the risks of falling. It also said they liked to spend time in the lounge but we did not see them in there during our visit. We saw very few people used the lounge and insufficient staff to be able to monitor people's movements. This meant the person's quality of life and choices about how and where they spent their time was limited because there were insufficient staff to manage the risks associated with their care and support needs.

On the first floor we saw many people were in their beds and not using the lounges. Staff we spoke with told us, "A lot of people who are in bed could be out." We were told it was because there were not enough staff to monitor or support people if they were not in bed. A visitor told us they felt their relative was on occasions, left in bed because they were safer there instead of walking around the corridors and being at risk of falling.

Current staffing levels meant that staff were not able to provide care that was person centred and met people's needs safely.

We saw many areas of the home were dirty. In the communal lounges we saw food debris on the carpets, tables and dining chairs, and stains on the lounge chairs. We saw people's wheelchairs were also dirty.

We looked at the cleanliness of people's bedrooms. We saw their en-suite bathrooms were clean but their floors and chairs were often stained or had dried on food which had not been cleaned up. The over bed tables where staff placed people's drinks and food were filthy. Care staff cleared plates from over bed tables leaving food debris which was not cleared up before the next course was served. The coffee tables in the lounges were sticky because they had not been wiped down. In one of the dining rooms we saw the bin was overflowing, and the fridge was dirty.

We spoke with housekeeping staff. They told us one cleaned each floor during daytime hours. However, they had been short of one member of staff, and sometimes there was only one housekeeper on duty for the whole home. There were no housekeeping staff to support cleaning duties in the evening. A relative told us, "Cleaners work hard but often do not have much time to clean or check 38 rooms, toilets and lounges. Sometimes areas are left messy for more than a couple of days." The manager told us they thought that there were sufficient numbers of housekeeping staff to keep people's living environment clean. They confirmed they had not requested the use of agency or bank cleaners to support their housekeeping staff in ensuring the home was clean.

This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst most staff had undertaken training in safeguarding, some of the practices we saw made us concerned that

Is the service safe?

people were not always safe and some staff were not putting their training into practice. For example, we saw many people in bedrooms did not have their call bells in reach despite them being able to use one. We heard one person who did not have a call bell in place crying out for a member of staff to assist them. They had a soft voice and staff did not hear them. We heard them as we were passing their room and alerted a member of staff.

We also heard another person call out that they wanted assistance with personal care, this time staff did hear them as they walked passed but the person was ignored. Another person was heard calling out behind a closed bedroom door and was again ignored by passing staff. When we checked on them with a member of staff it was found they wanted to use the toilet. A staff member told us that some staff would leave this person in bed all day with the bedrails up because it was easier. They said the person did not have capacity but staff knew when they shouted that they needed the toilet.

A relative told us they had complained to the deputy manager because there were several occasions when the call bell had been removed by night staff to stop their family member from calling for help to go to the toilet. The person told us that staff had told them to, 'go in your pad.' Another relative told us that whilst the care was 'generally good', they were not happy that at times their relation's call bell was out of reach. We saw call bells tied up or missing completely in some rooms. This meant some people's needs were being neglected because they were not being given the means to call staff for assistance. When call bells were in place and were used, we heard staff respond to them quickly. We raised the issue of call bells being out of reach with the registered manager and operations manager. They assured us they would rectify this.

A relative told us their relation should have their legs elevated when sitting in a chair to minimise the risks associated with their medical condition. We checked the person's care plan and saw this was documented. At no time during our visit did staff elevate the person's legs. The relative also told us the person had been living at the home for over a year and, "This is the first time she has had both foot rests on her wheelchair and a strap around her waist." This meant the person's risks were not being managed appropriately and their safety was compromised.

Another person had bandaged legs. We were concerned this person's legs were not elevated. We checked with staff and they confirmed they should be raised. We looked in their care file and there was no care plan regarding wound management and pressure area care. The nurse told us this was in a separate file, but care staff were not aware of this. There was very little information to support staff in understanding the risks relating to this person's condition and what to do to reduce the risks. The same person preferred to sleep on a chair all night to help with their breathing. There was no information in their care file about what the potential risks were for them in sleeping in a sitting position, and how these could be mitigated.

We visited the home during three very hot days. The home was uncomfortably warm, particularly on the first floor. We saw fans placed in corridors to help staff keep cool, and there were fans placed in some rooms for people. The fans for people were brought in by their relatives. Those who did not have visiting relatives were not supplied with a fan, and as a consequence their bedrooms were very warm.

The provider undertook monthly reviews of accidents, incidents and pressure ulcers. Where incidents had occurred, these had been investigated and action taken. For example, people had been referred to the 'falls team' when they had experienced a number of falls. We had concerns that accident and incidents were under-reported. This was because a relative told us they had seen and heard what they termed as 'aggressive arguments and pushing between residents' and seen people hitting out at other people, when staff were not present. Another told us their relation had more falls than had been recorded because staff were not around to see them.

We observed nurses administer medicines to people in the evening and during the day. We noted, whilst administering medicines, that they wore a tabard which requested that they were not disturbed. Nurses locked the trolley to secure the medicines inside whilst they delivered these to people in their rooms. We looked at a small sample of medicine administration charts and noted they were accurately completed. A medicines audit had recently been undertaken by the deputy manager. We saw this was thorough and had identified areas of medicines management which could be improved. We also saw the provider's regional operations manager undertook medicine management checks as part of their responsibilities and had identified when improvements were required in recording. These had been made which meant medicines were managed safely.

Requires improvement

Is the service effective?

Our findings

Relatives and staff who had contacted us before our visit, told us they had concerns that people who could not eat or drink independently were not receiving sufficient support. There were concerns that people were losing weight.

We spoke with people and their relatives about the help people received with food and drink. Some relatives told us people received sufficient support to ensure they ate and drank well; however seven relatives were concerned that staff did not have the time to give people the support they needed. For example, relatives told us," One day food was brought into the room [bedroom] just as we left, we went down in the lift and realised we'd forgotten something, and by the time we got back (within two minutes) the food was coming back out again." Another said, " I find [relation] with the tray in front of them with lunch untouched and cold, not eaten –it's been there for an hour. If I feed [relation] she eats it up." A third said, "[Person] needs encouraging to eat. They've lost weight. One carer told us he'd eaten, when we knew his food had been taken back."

We saw on the evening of our visit, one person sitting in the dining room who had been given a drink of coffee and a snack of sandwiches and crisps. Staff were busy doing other duties and not available to support or encourage the person to eat their food. The drink had gone cold and the sandwiches were left untouched. The person had gone to sleep sitting in the dining chair.

It was very hot during the evening and days of our visit. We saw lots of drinks had been given to people, however we saw many of these were not in reach. We went to one person's room and saw the jug of juice was by their television where they could not reach it. They told us, "The jug is over there and I'm here and never the twain shall meet. The last time I had a drink was breakfast." This was at 1pm. They told us they were thirsty. No staff were near this person's room so we filled their drinks container with juice. They drank it all up and asked for more. Another person had their drink on the window sill out of their reach. We asked the person if they wanted it, and they gestured that they did. They took it off us and drank it. We saw another person spilt their drink whilst they were attempting to drink it. A care worker came into the room and said, "It looks like [person] has had some". Most had been spilt.

Food and fluid charts we looked at had been completed. We asked staff when they completed the charts. They told us they should complete them at the time of providing the food and fluids but sometimes they did not have the time. For example, one member of staff said in response to a question about completing charts, "Staff don't have the time to push fluids; sometimes there are gaps in records because they do not have the time." Staff told us this meant they could not be sure food and fluid records were accurate.

We saw charts where people had consistently either 'refused' food or fluids. Some relatives told us they felt staff were too quick to report that a person had 'refused' to eat or to drink. They said people needed time to be encouraged to eat and drink, but felt staff were quick to take a 'no' as a 'refused'. One relative said, "They feed [person] but they are difficult. They have nice meals here, drinks are difficult to give – some staff are better than others, one will always make sure [person] has it all, some don't." Some staff told us they were so busy it was easier not to coax or encourage. Other staff told us they would always try to coax or encourage people to eat as much as they could. We saw two people being given good support to eat their food.

Where there were concerns about people's food and fluid intake, charts provided staff with the daily food and fluid goals for people. When these goals were not being reached we did not see instructions for staff to try and encourage people more to help them achieve those targets. The monthly audit about people's weight showed that of the 72 people who lived at the home, 40 had experienced weight loss since admission. The registered manager had made referrals to the dietician and the speech and language team when they had noted people's weight had dropped. Whilst we recognised some people were very ill and weight may have dropped as a consequence of this, we were concerned that in light of feedback we received from some staff members, some of the weight decreases could be linked to staff not having the time to support people with high dependency needs.

We contacted the community dietician who supported the home. They told us they had concerns about people with high dependency needs at Coundon Manor not receiving sufficient food and fluids to meet their nutrition and hydration needs.

Requires improvement

Is the service effective?

The registered manager and provider agreed to ensure more staff support at dinner times to enable people with higher dependency to receive the food and fluids they required to stay well.

This was a breach of Regulation 14 (Meeting Nutritional and Hydration needs) of

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people who could use the dining rooms and required minimal support with eating or drinking were provided with meals and drinks which met their needs. On the ground floor, where most people ate in the dining room, breakfast and lunch was provided to people in a relaxed and unhurried way. People received the food they had requested and were supported in an unhurried manner. People who were more independent were able to have snacks such as fruit, and drinks when they wanted them. Similarly the small number of people who used the dining room on the first floor had their lunch at their own pace.

We looked at the training provided to staff. We saw the majority of staff had undertaken the training the provider considered essential to meet people's health and social care needs. This included how to safeguard people, how to move people safely and infection control. We were concerned about the effectiveness of the safeguarding training as some staff had not made sure people had access to call bells.

Staff also received 'creative minds' training. This was training accredited by the University of Brighton to support staff understand and work effectively with people living with dementia. Staff on the ground floor responded well to people with dementia in the use of encouraging language, and in using distraction techniques to divert people from potentially challenging situations. One person liked to join staff in the office during their walk around the ground floor. However, staff told us they did not have the time to fully utilise the training they had received to improve the daily life for people with dementia.

We asked whether staff received supervision and appraisals to support them with their work. We received mixed responses. Some staff felt they had received supervision where their job was discussed and their training and development needs identified. Others told us that supervision meetings were only used to tell staff what they were doing wrong. One staff member said, "Supervisions are a joke, we are just getting told off, it is a stick." Another member of staff told us, "A supervision here is to tell you, you have done something wrong and to sign a piece of paper…you get called in to say what happened, go through it, they say it can't happen again, you sign it and are gone, we don't have supervisions otherwise, only if you've done something wrong."

The Mental Capacity Act is a law designed to protect adults who are unable to make decisions for themselves, and protects care workers and others who may have to make decisions on behalf of those who lack capacity. We asked staff if they understood the principles of the Mental Capacity Act. Staff we asked said they did, and one member of staff told us they had observed a mental capacity assessment to help them in their understanding. Care files demonstrated that most people's capacity had been assessed to help staff determine people's abilities to make decisions. Where people could not make their own decisions, decisions had been taken in their best interest. For example, some people had medicines in disguise (covertly). It had been decided by the relevant professionals that this was in their best interest.

The registered manager understood their responsibilities to apply for a Deprivation of Liberty Safeguard (DoLS) when people's freedom was restricted. Forty one applications had been made to the local authority and three had been approved. However, we were concerned that one person who had been assessed as having mental capacity to make their own decisions, felt they did not have the choice as to whether they wanted to use bedrails. They told us, "They put this bar up because I can't get out. I feel like a prisoner, and I don't want it up." Information in the person's care file identified bedrails were in place to support the person in their safety, however there was nothing to indicate the person had been involved in this decision and the person was clearly saying it was not what they wanted.

The GP visited Coundon Manor twice a week. We observed a staff handover meeting at the beginning of the day shift. The night shift leaders informed the day staff of people who had been unwell and needed to see the doctor. The staff faxed information to the GP prior to their visit so they would know who needed to be seen. When required, people had been referred to specialist teams such as the tissue viability clinic, the falls clinic, and to the Speech and Language Team.

Requires improvement

Is the service caring?

Our findings

We observed the majority of interactions staff had with people, was when undertaking care tasks. Relatives and staff both told us staff did not have time to sit and talk with people or respond to people's requests for assistance in a timely way. One member of staff told us, "People are not checked hourly, we do not have the time to run around every room every hour. When we do personal care, mealtimes and fluids is when we do see them. It is very task orientated." Another member of staff told us, "I think people have a poor institutional life here…it is difficult to know if people are getting the care, it feels like we are constantly chasing our tail." A third said, "It would be nice to have full staff and have five to 10 minutes to sit and talk to people, rather than just feeding them. I'm here 12 hours a day, these are my family, I want to be able to talk and have a chat with them."

Staff told us they had routines to try to meet the care needs of people as a whole as opposed to each individual. For example, staff told us when they woke people up to get them dressed, they went from one side of the home to the other. There did not appear to be a system which identified who wanted to get up early and that these needed responding to first. We looked at observation records. These were to provide information about what the staff had seen in relation to the person at hourly intervals during the day. Observations mostly recorded 'bed' to indicate the person was in bed or 'chair' to indicate the person was sitting in their chair. There was nothing to indicate how the member of staff observed the person's emotional or physical needs and how they responded to them, just the equipment they were sitting in or lying on.

During our visit we saw staff were kind and considerate in how they spoke with people who lived at Coundon Manor. Most relatives and people told us that individual staff were kind and caring, despite being very busy. One relative told us, "This has been a superb place; mother has been here since February. I haven't a bad word to say. All the members of staff are outstanding." Another said, "They have some lovely caring staff, but the impression is there are not enough staff." However, we saw instances where staff were not as caring. We saw a person cried out on a number of occasions. They initially cried out, "I want to go home" twice, and then called out, "Please, please." Once the staff had completed their tasks, they then responded to the person by giving them a cup of tea. This calmed them down, but it was 15 minutes from when they first started showing signs of distress.

People's dignity was respected when staff provided personal care. Doors to bedrooms were shut so people had privacy when they were being washed and changed. However, we saw many people were not offered something to cover their clothes before they ate and as a consequence spilt food down their clothes. We saw people sit in these clothes for long periods of time. We had identified this at our previous inspection in January 2015. At lunchtime, one person was seated on their own at a table which staff were also using to stack dirty plates and to scrape the remains of people's dinner. This did not respect or treat the person with dignity whilst they were eating their own meal.

One person told us they were not allowed to go to the toilet during meal times. They said they had been told this was due to 'cross contamination' (taking someone to the toilet and then delivering food would mean changing aprons and gloves, and washing hands). We asked staff whether people were unable to be taken to the toilet when meals were being provided. One member of staff told us they couldn't because of cross contamination. Others told us it was a challenge to take people to the toilet whilst providing meals because it meant it would take longer to get the meals to each person, but this would not stop them from taking the person. During our visit we saw staff take people to the toilet on request.

Staff were not employed to work on a specific floor. We were told this was to provide more flexibility when covering staff absences. However, for people living with dementia this could be more confusing as they did not get familiar with a regular and consistent staff group. One relative whose relation lived with dementia told us, "They are all very nice but they [staff] can't get used to the patients because they move around to different areas. I wonder who is on today. I would like more consistency so [person] knows them."

One person had a birthday during our inspection. A room was specially decorated for the person so they could have a tea party with their friends. The person told us, "The home put on an amazing tea" and it was a, "Beautiful cake." They told us the staff were willing to do extra to ensure that they had a good time. When the friends of the person arrived, all the staff were called to the room to sing 'happy birthday'.

Requires improvement

Is the service caring?

There were no restrictions in visiting times for friends and relatives of people at Coundon Manor. When we arrived at 8.45pm there were still relatives visiting their relations, and throughout the day we saw many people visit and stay long periods of time to support people who lived there.

Requires improvement

Is the service responsive?

Our findings

Each person had a pre-admission assessment to determine what their needs were and how staff could support them with this. Many of the people living at Coundon Manor could not speak for themselves and relied on their relatives to act as their advocates and to provide information to the home about their needs. One relative told us an assessment was undertaken in the hospital without family and the next day the person was living at Coundon Manor. They said they visited regularly and had not been approached to discuss their relation's needs since the person moved into the home a few months previously. Another relative, who again visited regularly, told us, "None of the management came to talk to find out about [person], until it was requested by us. We requested it because we were unhappy with the care [person] was receiving."

We looked to see if people were provided with personal care the way they would like to receive it.

We looked at the daily charts and saw people usually received a wash and mouth care in the morning, although there were some occasions when records suggested this had not happened. For example, one person's records indicated they had not had a wash for three days. We looked at the charts for personal hygiene in the afternoon and evening. We saw many instances where there was no record that people had been washed or had their teeth cleaned at night.

We asked a member of staff whether they cleaned people's teeth in the evening. They told us they only cleaned one person's teeth in the evening because they had requested it. A relative informed us their relation did not have their teeth cleaned at night. They told us, "[Person's] teeth are regularly not cleaned. If given the toothbrush they will largely do this themselves. There are regular occasions when it is absolutely apparent this has not been offered. If you look at the chart, staff appear to record 'refused' and while we accept this may be the case on a few occasions, this occurs often."

We checked whether people were supported to have regular showers or baths. We were told people normally had one shower a week, and this was crossed off in the shower book to ensure they had a shower. We were concerned whether the frequency of this ensured that people's personal hygiene needs were met. We checked the shower records and found two people had waited longer than a week to have their shower. There was nothing in the records to say the person had refused. One visitor told us they had to shower the person because there were not enough staff to give the person the number of showers they would like a week. Another relative told us they were re-assured their relation would have a shower every day, but this was not happening, again because there were not enough staff.

A person who smoked was not being supported to have a cigarette when they wanted one. We saw an entry in the daily notes recorded at 12.40pm that read "[Person] has been shouting for cigarettes since the start of the shift (8am). I explained they needed to wait as everyone was busy."

At our last inspection in January 2015, 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 to them to support people who were not able to undertake group activities. This meant the activity worker had very limited time to spend with people on an individual basis so that they could pursue their hobbies or interests.

During this visit we saw that the number of hours for activity support had not increased and people who were unable to engage in group activities continued to have little input from the activity workers. This meant people with higher dependencies experienced very little social and emotional stimulation, and spent most of their time alone in their bedrooms

Whilst the care plans showed staff had tried to get information about people's personal histories, hobbies and interests, the information was not very comprehensive and we could not see it had been used to plan individualised care and support. For example, we spoke with one person who told us it was very important for them to receive Holy Communion each week. They told us they had informed staff of the importance of this to them but it had not been arranged.

This was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

The provider had a complaints policy and procedure. We saw formal complaints were addressed by the manager in accordance with the policy. We noted there were many informal concerns that the manager and staff had dealt with, with mixed views on the outcomes. On relative told us, "The manager is very approachable, she listens and does something. The other day I was angry that [person] had two blankets on her, it was a very hot day, I nearly cried, but this was an isolated case. She responded straight away, which was good." Another said, "If I have a concern, you can speak to anyone, they are very good, responsive. I am happy with [person] being here."

However, a person and some relatives told us about their less positive experiences of informal complaints. One person told us, "My daughter is always ringing the office; I didn't know they had a manager until the other day. They should look more and come round to see what's going on."

A relative said, "I have had numerous meetings with [the registered manager] and [the deputy manager]," and they felt care had not improved. Another said, "From a relative's point of view it has been heart breaking to repeatedly voice your concerns to no avail. They told us of the pain of, "Watching your loved one deteriorate with dementia, when staff cannot see the distress raised when dignity is breached."

When meetings had taken place with relatives to discuss concerns, the information from the meetings was held in the person's care file. This meant the registered manager and provider could not analyse the number of informal complaints and determine whether there were trends or patterns in concerns raised. Staff also told us they had informed the manager of concerns they had about staffing, but we could not see this information logged.

Inadequate

Is the service well-led?

Our findings

Since registration with the Care Quality Commission, the home has not consistently been compliant with the regulations. In 2012, under our previous method of inspecting, the service was not compliant with the regulations in any of the five outcome areas we inspected, one of which concerned the number of staff required to support people's needs. We followed this up early in 2013 when the service remained non-compliant in staffing. In late 2013 we inspected the service again, and the service became compliant with staffing. In June 2014, after receiving concerns from whistle blowers and the public, another compliance inspection took place, and again the provider was found non-compliant in the five areas inspected (this included staffing). The provider improved the service, and by November 2014 the service was compliant with the regulations. By January 2015 when we inspected again under the rating system, the service was rated as 'requires improvement'.

The registered manager at this inspection had been in post since July 2014, and was registered with the CQC in February 2015.

There were mixed views about the leadership of the home. Some people and relatives thought the home was well managed, and others thought the leadership was not effective as they did not respond to concerns raised.

We last inspected the home in January 2015. At this inspection, the manager told us there had been a dip in staff morale as a consequence of some management issues, but they had put systems in place to improve morale and to help staff feel valued and supported. At this inspection, many staff we spoke with did not feel valued and listened to, and their morale was low.

We were told previous staff incentives were stopped, and there was no reward system to praise or encourage good care. There had been no team meetings since our last visit, and 'flash' meetings which had been introduced prior to our last inspection were no longer happening. A 'flash' meeting was a daily meeting with senior staff to ensure staff were aware of any new or important issues impacting on people who lived at the home.

We asked staff if they felt supported by the leadership to help them deliver effective care and support to people. We had mixed views from staff. One member of staff told us they had a good relationship with the manager and they felt they were able to give their opinions. Others told us, "Managers have never given praise, but team leaders and nurses do this. I have never spoken with the registered manager since the first week." Another said, "The way the staff get treated, you can understand why they've left. I've helped out a lot and get no thank you for it. It would be lovely if at the end of the shift they said thank you, it goes a long way." Some staff told us they did not feel supported to raise concerns with management.

Staff had received supervision, but many staff felt supervision was a management tool for telling staff they were wrong. We saw letters to staff outlining management concerns which were classed as 'supervision'. For example, staff received a supervision record of concern about supplementary charts (food and fluid) not being checked to a satisfactory and safe standard, and another regarding dining room and satellite kitchens not being tidy and meeting food hygiene requirements. We were told by both management and staff that this was given to staff to sign to confirm they understood the directive and if they did not carry out the management instruction it would be considered as gross misconduct. We saw nothing in this system to indicate whether staff had the opportunity to discuss why they felt the standards had not been met and how management might be able to support them in meeting the standard.

Since our last inspection in January 2015, 12 care workers and four nurses had started working for the organisation, and nine care workers and five nurses had left.

We did not see effective communication between the care staff, nurses, team leaders, catering, housekeeping and management of the home. By walking around the home and speaking with staff, relatives and people who used the service, we were able to see parts of the home were dirty, there were not enough staff to provide anything other than task focused care, and people with high dependency needs were not always getting the food and fluids, or personal care they required. We were concerned the management of the home, and management systems of the provider, had failed to identify these. For example, we saw on our visit as the day progressed, there was not enough crockery and cutlery available for use. A member of staff told us, "We always run out of plates, beakers, lids, cutlery, and side plates." They told us this meant they had to spend time

washing up the ones from the morning. When we informed the manager of this, they told us they were not aware this was the case, and if they had been, would have approved for more to be purchased.

The registered manager was supported by the provider's Operations Director who visited the home once a month. The Operations Director was relatively new to the organisation. We saw their monthly visit report which identified some of the issues we found but not to the extent of our concerns. For example, in their May report they had checked a person's care plan and identified concerns in relation to the amount of food and fluids the person had received. They had identified one member of staff was on long term absence from work, but the record showed they had identified no other staffing concerns at the home. They acknowledged to us that their visits were not as comprehensive as our inspection and they would want to work with us to improve on any areas we had identified as needing action.

This was a breach of Regulation 17 (good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Recently a new tier of leadership, 'clinical leads' had been introduced to the home. A clinical lead is a qualified nurse who focuses on the quality and safety outcomes for people in their care. One of the clinical leads had been working at the home for four weeks and the other appointed lead was due to start. Staff were positive about this development. A member of staff said, "The clinical lead is brilliant, she makes sure things are OK, she's really good for this home." The clinical lead was counted in the numbers for nursing cover, but was provided with 11 hours of time off the rota to undertake staff supervision and to look at the quality of care provided. We discussed with the provider whether 11 hours would be sufficient to meet the staff's development needs.

The registered and deputy managers told us they were engaging with nursing staff to ensure that nurses delivered 'hands on' care to people as well as specific nursing tasks. Care staff told us they felt that nurses who were more 'hands on' provided better support to them than nurses who would not do this. The deputy manager told us they were leading by example. They undertook shifts and provided 'hands on care'. Staff we spoke with had welcomed this.

After our visit we spoke at length with the operations director and met with the provider of the service. They had listened and responded quickly to the feedback we had given at the end of our visit. Within one week of our visit, they had put together an action plan to increase staffing, to motivate and improve staff morale and leadership, and to improve cleanliness of the home. They agreed to send us monthly updates to inform us how their action plan was working, and any other issues noted. They also agreed to increase the amount of 'off rota' time for the clinical leads.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: People were not receiving the personal care they required to be safe, because there were insufficient staff to meet their needs. People who required support with eating and drinking did not always receive the support or encouragement needed because there were not enough staff. The home was not sufficiently clean because there were not enough cleaning staff.

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 How the regulation was not being met: Care was task focused, 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.

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 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: People with high dependency needs, were not being provided with the support required to help them eat and drink sufficient food and fluids to maintain their health.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

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

How the regulation was not being met:

The registered manager and the provider's quality assurance systems had not assured quality of care for all people who used the service.