

Amore Elderly Care Limited

Coundon Manor Care Home

Inspection report

1 Foster Road
Coventry
Warwickshire
CV6 3BH

Tel: 02476600860
Website: www.priorygroup.com

Date of inspection visit:
10 May 2022
18 May 2022

Date of publication:
20 July 2022

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Coundon Manor is a care home and is registered to provide personal and nursing care for up to 74 older people including people living with dementia physical disabilities and sensory impairments. At the time of our inspection 53 people lived at the home and one person was in hospital.

People's experience of using this service and what we found

The quality and safety of the service had deteriorated since our last inspection. The lack of provider oversight and instability within the management team meant previously demonstrated standards and regulatory compliance had not been maintained. The provider's systems and processes designed to identify shortfalls, and drive improvement were not always effective. Opportunities to learn lessons had been missed.

The limited availability of staff and lack of training completed by some staff negatively impacted on people's safety and experiences of living at Coundon Manor. In addition, some staff training was not up to date. Action was planned to address this. Risks associated with people's care were not always assessed and well-managed. Some aspects of medicines management and the prevention and control of infection required improvement.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Improvement was needed to ensure people's experiences at mealtimes were positive. Plans were in place to refurbish and develop the environment of the home to ensure it was a nice place for people to live.

Despite our findings people and their relatives felt the service was safe. Permanent staff were recruited safely, and staff understood their responsibilities to keep people safe. People had access to health and social care professionals. The management team were working towards creating a positive culture within the home.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was good (published 19 April 2019).

Why we inspected

We received concerns in relation to staffing and management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Coundon Manor on our website at www.cqc.org.uk.

Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people's safety, protecting people's liberties, and the management of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Coundon Manor Care Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

Our first inspection visit was undertaken by two inspectors, a specialist advisor and an expert by experience. A specialist advisor is a qualified health professional. Our specialist advisor was a registered nurse who had expertise in supporting older people and people living with dementia. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Two inspectors returned to the home to complete a second inspection visit.

Service and service type

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

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. An interim agency manager was supporting the home whilst active recruitment was taking place.

Notice of inspection

Both of our inspection visits were unannounced.

What we did before the inspection

We reviewed information we had received about the service since they registered with CQC and sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

During the inspection we spoke with nine people who lived at Coundon Manor and six people's relatives to find out what it was like to live at the home and to gather their experience of the care provided. We spoke with 22 members of staff including the managing director, the operations director, the interim manager, one of the provider's quality improvement leads, an assistant director of quality, nurses, senior care assistants, care assistants, the administrator, a hostess and the housekeeper. We also spoke with a visiting health care professional.

Some people were not able to tell us what they thought of living at the home; therefore, we used different methods to gather experiences of what it was like for them to live there. For example, we observed how staff supported people throughout the inspection. We also used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

We reviewed a range of records including nine people's care records and 18 people's medication records. We looked at three permanent and three agency staff files in relation to recruitment and support. We also reviewed records relating to the management of the service, including staff training information, the provider's quality monitoring systems, processes, policies and procedures.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- Low staffing levels and the high use of agency staff impacted negatively on people's safety and their experiences of living at Coundon Manor.
- People shared mixed feedback when we asked them if there were enough staff on duty to meet their needs. One person described feeling upset because they had to wait for assistance to go to the toilet. They said, "They are short staffed. Run off their feet." In contrast another person told us staff did respond in a timely manner when they activated their call bell.
- Relatives and staff told us staffing levels were too low. Comments included, "They [staff] do their best but they are so very rushed," and, "It's very stressful. We need more staff, working with agency is very difficult, especially if they (agency staff) haven't been here before."
- Staff provided examples of how the use of agency staff had a negative impact on people. Staff described how people with swallowing difficulties (Dysphagia) had to wait for staff assistance to eat and drink because agency care assistants on duty had not completed training in this area and their competency to support people safely had not been assessed. (Dysphagia is a swallowing disorder which can increase the risk of choking when eating and drinking.) We were assured this would be addressed and when we returned on day two some competency assessments had been completed. However, an agency care assistant who had supported a person with dysphagia to have a drink confirmed their competency had not been assessed. This was unsafe practice and placed people at risk.
- We saw how the low staffing levels impacted negatively on people's experiences during both of our visits. This included people having to wait for their breakfast and assistance with their personal care. In addition, during our second visit we saw some people were sat in their wheelchairs outside the nurse's office. When we asked a staff member about this they replied, "We park them there while we do handover and help the others to get up. They [people] can't go in the lounge because there's no one (staff) to watch them." This practice demonstrated a poor culture underpinned by a task centred approach operated and was accepted within the home.
- Our findings confirmed the provider's process to determine the number of staff they needed on duty to provide safe care was not effective. The interim manager told us, "At the moment it (process to determine staffing) suggests we are overstaffed but what looks like good numbers is depleted as it does not take geography (layout of the home) or the number of people cared for in their rooms into account."

We found no evidence that people had been harmed however, the provider had failed to ensure there were sufficient numbers of suitably qualified staff available to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Permanent staff had been recruited safely in line with the provider's procedures. However, the provider could not demonstrate checks had always taken place to ensure agency staff working at the home were suitable. We alerted the managing director to this, who gave assurance it would be addressed. When we returned required checks had taken place.
- The interim manager and operations director described staff recruitment as the biggest challenge the service faced. They explained the actions they had taken and those planned to try to address this, including block booking agency staff and on-going recruitment drives.

Assessing risk, safety monitoring and management

- Risks associated with people's care were not always assessed and well-managed. This placed people at risk of harm.
- Staff had failed to follow instructions to mitigate risks. One person had a pressure wound and to prevent further skin damage occurring staff were instructed to assist the person to move the position of their body every two hours. Records showed that had not happened. This increased the risk the person may experience further damage to their skin.
- Another person's risk assessment instructed staff to complete hourly safety checks because the person was unable to use their call bell to summon staff assistance. The checks had not been completed. A nurse told us, "We have recently introduced hourly checks, but staff are not used to them yet." The person's risk assessment was dated 28 October 2021.
- A third person had bedrails fitted to their bed to reduce the risk of them falling out. Their risk assessment instructed staff to complete hourly safety checks. Again, records confirmed staff had not followed this instruction. This exposed the person to the potential risk of avoidable harm.
- Some risk assessments contained incorrect information which placed people at risk of receiving unsafe care. For example, one person's risk assessment documented they were at medium risk of their skin becoming damaged. A nurse confirmed this was incorrect. They explained the person was at high risk because they were prone to and had skin damage which required medical intervention. They added, "Part of the problem is we have never had training on how to do the risk assessments." The nurse assured us the person's risk assessment would be re-written.

We found no evidence that people had been harmed however systems to assess, monitor and mitigate individual risks to the health, safety and welfare of people using the service were not effective. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff completed fire safety training and understood the action they needed to take in the event of an emergency.
- The homes contingency plan was up to date and provided staff and the emergency services with the information needed to keep people safe in the event of, for example, a fire.
- Accidents and incidents, including falls were documented. A monthly analysis of the information highlighted any patterns or trends which was used to identify if lesson could be learnt to reduce the risk of reoccurrence.

Preventing and controlling infection

- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Records did not show the frequency at which high touched points, for example door handles had been cleaned and some areas of the home were not clean. The provider had arranged for the home to be deep cleaned by an external company.
- We were somewhat assured that the provider was making sure infection outbreaks were effectively

prevented or managed. Staff had received training in the prevention and control of infections. However, staff practice indicated they did not always follow their training.

- We were somewhat assured that the provider was using PPE effectively and safely. Relevant signage was visible in required areas and staff had received infection prevention and control training. However, on occasions some staff wore their masks below their noses which was unsafe practice.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service
- We were assured that the provider was accessing testing for people using the service and staff.

Visiting in care homes

- The provider facilitated visits for people living in the home in accordance with current guidance.

Using medicines safely

- Some aspects of medicines management required improvement. The competencies of staff responsible for applying prescribed creams and lotions to people's skin had not been assessed as required by the provider's Management of Medications policy.
- Some prescribed creams located in people's bedrooms did not have the date of opening recorded. This is important to ensure creams remain effective. In addition, records did not show creams had been consistently applied as prescribed.
- Tablet form medicines were stored, administered and disposed of safely.

Systems and processes to safeguard people from the risk of abuse

- Despite our findings people felt safe and relatives had no concerns about their family members safety.
- Most staff had attended safeguarding training and demonstrated some understanding of their responsibilities in relation to this.
- The interim manager told us they understood their responsibility to work in line with the provider's safeguarding systems to keep people safe from harm and to share information with the local authority safeguarding team and to CQC to ensure any allegations or suspected abuse were investigated.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection this key question was rated good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- The provider had failed to ensure people's rights were consistently protected and upheld in line with the requirements of the Mental Capacity Act.
- On day one of our inspection some people's liberty was being unlawfully restricted. Some people who lacked capacity were seated in specialist chairs, which when tilted backwards restricted their movement. Mental capacity assessments and best interest decisions had not been made on behalf of those people.
- People's movement was further restricted when seated in specialist chairs by the use of lap belts. Staff confirmed the lap belts were used to prevent people from falling out of the chairs. In addition, the use of lap belts had not been risk assessed which was unsafe practice. Whilst the provider's quality improvement lead told us action was planned to address this, timely remedial action had not been taken. When we returned for our second visit some people's liberty continued to be unlawfully restricted because mental capacity assessments and best interest decisions had not been completed for all people who needed them.
- Other people's mental capacity assessments did not evidence the principles and process for assessing their capacity had been followed. The assistant director of quality acknowledged our findings and said, "There is work that needs to be done around MCA."

We found no evidence that people had been harmed however, the provider had failed to work within the requirements of the MCA Act 2005. This was a breach of regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During day two of our inspection visits the assistant director of quality told us to drive forward improvement they had completed a 30-minute MCA flash training session with staff which had been well-received. Further training sessions were planned.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People's needs were assessed prior to moving into Coundon Manor to ensure their needs could be met.
- Nurses used the information gathered during the assessments to begin to develop people's care plans. One relative commented, "We had a chat with the nurse to make sure they knew what [Name] liked and needed. They wrote it all down. That was reassuring."
- People had access to a range of health and social professionals.
- Nurses consulted with healthcare professionals. During our visit we heard a nurse seeking clarification from a health care professional who had not shared the outcome of their visit to a person. Another person received a visit from a specialist continence nurse.
- The operations director and interim manager, despite the short time they had been in post, felt they were developing positive working relationships with commissioners and health and social care professionals which they valued.

Staff support: induction, training, skills and experience

- Staff, including agency staff received an induction when they started working at the home. However, some agency staff were not able to recall the content of their induction.
- Some staff training was not up to date to ensure staff had the training and skills they needed to provide effective care. The quality improvement lead had already identified this shortfall and training had been scheduled. Staff had been informed of the provider's training requirements and the date by which it needed to be completed. When we returned records confirmed some training had been completed within the timescales.

Adapting service, design, decoration to meet people's needs

- Further consideration was needed to ensure the environment met people's needs, particularly the needs of people living with dementia. The operations director had identified this and told us they were seeking 'support and inspiration' from one of the provider's other specialist dementia homes.
- Some areas of the home environment were in need of updating. The provider had approved a programme of refurbishment which was scheduled to start in Autumn 2022.

Supporting people to eat and drink enough to maintain a balanced diet

- Overall, people provided positive feedback about the food. However, one person told us they regularly had to ask staff to reheat their meal. The person said, "It's annoying when the food is cold. The chef sends it down hot, but when I get it it's cold or just warm."
- A relative told us on one occasion they had needed to alert staff their family member had not been provided with a lunchtime meal.
- People did not benefit from a positive meal-time experience. Dining tables were not laid with cutlery or condiments and some people had to wait for their meals to be served or for staff to be available to assist them to eat. The quality improvement lead had identified mealtimes as an area requiring improvement and was planning to address this.
- Thickening agents prescribed for people who had swallowing difficulties were not managed or stored in line with the provider's policy and procedure. During each inspection visit the cupboard used to store prescribed thicker was not locked. This was unsafe practice as there was a risk people could access and

consume the thickening agent which cause them harm. Action was taken to address this.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating for this key question has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;

- Information we received prior to our inspection indicated the service was not consistently well-led. Our inspection findings confirmed that was correct.
- The provider had not maintained sufficient oversight of the service provided to people. Our inspection findings and the breaches of regulations confirmed the quality and safety of the service had deteriorated since our inspection in May 2019. This exposed people to unsafe care.
- The provider's quality audits and checks were not always effective. Audits of care records had not identified some risk assessments did not provide staff with the information they needed to help them provide safe care. Some audit action plans did not include identified shortfalls and the actions needed to address these. For example, the management of prescribed creams and thickening agents. This meant opportunities to improve safety and drive improvement to benefit people had been missed.
- The management team had not ensured the care and support people received was consistently safe and effective as detailed within this report. In addition, the management team had not followed the provider's operating procedures which meant some information was not easily accessible during day one of our inspection visits.
- Whilst we acknowledged the provider's recruitment challenges, they had not ensured there were sufficient suitably qualified staff on duty to meet people's needs. This placed people at risk.
- The provider did not have systems in place to ensure they had met their responsibilities in relation to Mental Capacity Act 2005, which placed people at risk of being unlawfully restricted.
- Some staff did not feel valued or supported and told us they were reluctant to speak out for fear of repercussions. This indicated a closed culture in the home.

We found no evidence that people had been harmed. However, governance and service oversight was not effective and systems and processes were not operated correctly. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to effectively deploy sufficient trained staff to meet people's needs.

- Other staff felt the support available to them had improved since the operations director and interim manager had been in post. One staff member said, "They have been brilliant." The operations director

acknowledged some staff had found the 'turbulent nature of management arrangements' unsettling. They added, "We have done a significant amount of work with staff to re-build trust. We have created an open-door policy. We need staff to know and feel they are valued, and we need their support to move forward."

- The home did not have a stable management team. The provider was actively trying to recruit a permanent home manager, deputy manager and clinical lead. Day to day management support was provided by an interim manager who had been in post for nine weeks. They said, "I've never felt people are not cared for, but operational governance has fallen into a muddle. There is a lot to do. There are no quick fixes."
- The latest CQC inspection rating was on display in the home and was available on the provider's website. The display of the rating is a legal requirement, to inform people, those seeking information about the service and visitors of our judgements.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others;

- The interim manager and operations director understood their responsibilities to be open and honest when things had gone wrong.
- Relatives told us they had opportunities to provide feedback about the service through 'engagement' telephone calls which they valued. One relative told us, "[Name] has come on leaps and bounds since being here. We are pleased." A visiting health care professional commented about recent improvements in communication with nurses and staff which they viewed as positive.
- The management team had devised an improvement plan. Further work was needed to ensure the plan included all areas for improvement, the action required to achieve this and the timescales for actions to be completed, coupled with the need for additional management support to enable the plan to be achieved. The operations director said, "I have full confidence we can get things done. The foundations are there, the care is there. Now we need to put it all back together."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Regulation 11 (1) HSCA RA Regulations 2014 Need for consent The provider had not ensured restrictions on people's liberties were authorised in line with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 (1) (2) (a) (b) (c) HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people's care and treatment was provided in a safe way. The provider had not ensured risk associated with people's care was identified and assessed. The provider had not taken all reasonably practical steps to mitigate risk associated with people's care. The provider had not ensured all staff had the skills and competence to provide safe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) HSCA RA Regulations 2014

Treatment of disease, disorder or injury

Staffing

The provider had not ensured sufficient numbers of suitably trained, competent staff were available to meet people's need.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) HSCA RA Regulations 2014. Good governance</p> <p>The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided.</p> <p>The provider had not ensured they had effective systems and processes in place to identify assess and mitigate risks relating to the health and safety and welfare of service users.</p> <p>The provider had not ensured records relating to the care and treatment of each person using the service were accurate and up to date</p>

The enforcement action we took:

Warning Notice