Avonpark Village (Care Homes) Limited

Fountain Place Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Fountain place is registered to provide accommodation for up to 17 people who require nursing and/or personal care. The home is located in Avonpark Village, which is a purpose built village for people over the age of 55. At the time of our inspection there were 11 people living in the home.

We carried out this inspection in response to concerns raised relating to the quality of care and support people were receiving. These concerns related to all three locations, Hillcrest Care home, Alexander Heights Care Home and Fountain Place Nursing Home which are all located in Avonpark Village. Due to this we inspected all three locations. The inspection took place on the 18, 19 and 23 May 2016 and was unannounced. At our last inspection at Fountain Place in July 2015 we found the provider did not meet some of the legal requirements in the areas we looked at. The provider wrote to us with a plan of what actions they would take to make the necessary improvements. We found during this inspection that the provider had not undertaken all the necessary improvements required to fully meet people's needs.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider. 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. The registered manager was not present during our inspection. We found the service was not well led.

People were not always protected from the risk of harm. Whilst risks were identified, people's care plans did not always contain guidance for staff on how to minimise the risk and in some cases the care plans contained conflicting information.

Accidents and incidents were not always recorded appropriately and reported to the management team. This meant that we were unable to clarify if incidents had been followed up and where necessary appropriate actions taken.

People were at risk of not receiving appropriate care and support to meet their current needs. Care plans did not always contain up to date information and guidance for staff to follow. In addition we found some information relating to people's care, support and treatment to be contradictory.

We observed caring and friendly interactions between staff and people using the service. People and relatives spoke positively about the staff and the care and support they provided. There was an activities programme, however opportunities for social engagement were limited and some people living in the home did not access meaningful activities to avoid social isolation.

People were supported to eat and drink sufficient amounts and maintain a balanced diet. People had access to specialist diets when required. However there was a risk people were not always receiving food and/or fluid at the right consistency due to the conflicting information provided to staff.

Mental Capacity Act (MCA) 2005 procedures were not clear for staff to follow. Records were not maintained to show the process followed by the staff to assess people's capacity and making best interest decisions. Staff did not always know who should be the decision maker in best interest decisions.

Problems with the service and required improvements were not always identified. We did not always see evidence of actions taken where concerns had been highlighted. Not all staff felt they were supported by management to raise concerns or question practice. They did not feel that concerns raised had been acted on and responded to appropriately.

There were safe medicine administration systems in place and people received their medicines when required. Records confirmed people had access to health care professionals as required such as a GP or consultant specialist.

Staff we spoke with told us they had received training in safeguarding vulnerable adults and were able to explain how they would recognise and respond, should they suspect abuse was taking place. However staff were not always confident that any concerns raised would be listened to and acted upon. People and relatives told us they or their relative felt safe living in Fountain Place.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

People were not always protected from the risk of harm. Whilst risks were identified, people's care plans did not always contain guidance for staff on how to minimise the risk.

People were not always supported by suitable staff who knew them well and were aware of their care and support needs.

People's medicines were managed so they received them safely.

Staff knew how to identify the signs of abuse and could explain what actions they would take should they suspect abuse had taken place or people were at risk of harm.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive regular supervision with some staff not feeling supported to carry out their role or raise concerns. Staff did not always feel confident that concerns raised would be addressed appropriately.

People were supported to eat and drink sufficient amounts and maintain a balanced diet. People had access to specialist diets were required. However there was a risk people were not always receiving food and/or fluid at the right consistency.

Mental Capacity Act (MCA) 2005 procedures were not clear for staff to follow. Records were not maintained to show the process followed by the staff to assess people's capacity and making best interest decisions.

Is the service caring?

Requires Improvement

The service was not always caring.

At the time of our inspection the service was using a high amount of agency. As agency staff did not have time to read care plans people were at risk of receiving care from staff who were not aware of their personal preferences.

People's privacy and dignity was respected and maintained.

People were able to maintain relationships which were important to them. Relatives told us they were welcome to visit anytime.

People and relatives were positive about the care and support they received.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care plans did not always contain the most up to date information to enable staff to be responsive to people's needs. Information within care plans was contradictory.

There was a general activity programme in place. However, there were not enough meaningful activities for people to access in groups or as individuals to avoid social isolation.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have effective systems in place to assess, monitor and improve the quality of care.

Problems with the service and required improvements were not always identified. We did not always see evidence of actions taken where concerns had been highlighted.

Not all staff felt they were supported by management to raise concerns or question practice. They did not feel that concerns raised had been acted on and responded to appropriately.

Fountain Place Nursing 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.

We carried out this inspection in response to concerns raised relating to the quality of care and support people were receiving. These concerns related to all three locations, Hillcrest Care home, Alexander Heights Care Home and Fountain Place Nursing Home which are all located in Avonpark Village. Due to this we inspected all three locations. All three locations are registered with CQC separately and as such all three have a separate inspection report. All reports can be found on the CQC website. As we found there were some similar themes relating to the service provision in all three locations some of the findings in the reports will be repeated. The inspection took place on the 18, 19 and 23 May 2016 and was unannounced. This inspection was carried out by two inspectors for each location with support from an inspection manager. On the third day two inspectors and CQC pharmacist inspector attended covering the whole site

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We used a number of different methods to help us understand the experiences of people who use the service. This included talking with five people who use the service and two relatives about their views on the quality of the care and support being provided. During the three days of our inspection we observed the interactions between people using the service and staff

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included five care and support plans and daily records, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the regional manager, the deputy manager, three registered nurses, five care staff, which included agency workers, and the activity co-ordinator. We spoke with housekeeping staff and staff from the catering department.

Inadequate

Is the service safe?

Our findings

People were not always protected from the risk of harm. Care plans we reviewed contained risk assessments in relation to falls, keeping people safe, moving and handling and skin integrity. However, although risks were identified, the care plans did not always contain detailed information for staff on how to minimise the risks and in some cases, the plans contained conflicting information. For example, one person needed assistance with moving and transferring safely. A moving and handling assessment had been completed and had been reviewed monthly. Staff had documented in the person's moving and handling plan 'If X needs to transfer out of bed they would need a hoist with at least 3 carers to assist to prevent injury to lower limbs'. However, later in the same person's personal hygiene plan, staff had documented 'Requires the assistance of 2 staff for all care'. This meant there was a risk of staff not being aware of which guidance they needed to follow in order to keep the person safe. Despite this, the care plans in relation to supporting people who needed to use a hoist did contain details of the type of hoist that was required and the size of sling that should be used for the person.

We found people did not always receive care as planned when needing assistance with safe moving and transferring. People were cared for by staff who were unfamiliar with their needs due to being agency and bank workers. Agency and bank staff were given an 'Agency information sheet' which provided a basic overview of people's mobility, nutritional and personal care needs. There were no permanent members of staff on duty until a registered nurse arrived mid-morning. When observing the staff handover on the second day of our inspection it came to light that staff on our first day had not been able to locate the hoist required to move people who required it. When we asked the staff member how those people who had been identified as needing a hoist were supported their reply was "We had to use a slide sheet". This meant that people did not necessarily have a choice about how they received their care. For example, some people preferred to be hoisted on to a commode but as the hoist could not been found this option had not been available. Although staff told us the person had chosen to use a bed pan on that day, had they wanted to use the hoist they would not have been able to access it.

Although people were provided with call bells, not all were able to use them due to cognitive impairment. In two plans we looked at, the inability to use the call bell had been documented and staff directed to check the person every hour. However, there were no formal observation charts in place and staff did not sign to confirm they had checked the person was safe and well every hour. One person using the service who was able to use their call bell said "I have my pendant call bell and when I ring it someone always comes quite quickly".

Three of the care plans we looked at contained plans for people who occasionally displayed behaviour that staff or other people using the service may find distressing. Although these plans contained some guidance for staff there was not enough detail to inform them how to minimise the risk of distress, and how to keep themselves and the people using the service safe. For example, in one person's plan it was documented that the person had 'mood swings, agitation, confusion' and 'becomes confused and physically rude'. The guidance for staff on the handover sheet contained the statement 'Lashes out especially during personal care'. There was no detail within the care plan for staff on how to support the person should they become

physically rude or aggressive, other than 'speak slowly; ask permission for all procedures and for procedures to be explained in a step by step calm manner'. In another person's plan in the behaviour and mood section, staff had documented 'can exert challenging behaviour, verbally and physically'. In the personal care section, staff had also documented 'starts to scream and shout and swear at staff and pinch'. There was no information on how staff could prevent or minimise these behaviours, if there was anything in particular that might trigger such behaviours or how staff should act in order to keep themselves and the person safe. This meant that there was a lack of guidance for staff to follow to ensure people were supported with managing their behaviour in a consistent manner.

Accidents and incidents were not always recorded appropriately and reported to the management team. For example, we saw in one person's care plan two recorded incidents of unexplained bruising. There was a statement from staff relating to one incident of bruising and photographs and a body map and photographs of another incident but no further detail. We could find no completed incident forms for either of these two situations. We spoke with the deputy manager who told us they had not been made aware of these incidents and was unable to clarify if the incidents had been reported. This meant that we were unable to clarify if the incidents had been reported, followed up and where necessary appropriate actions taken. When we asked the deputy manager where the accident and incidents forms were kept, we were told they were sent to a central office and copies should be available in people's care plans. On this occasion accident and incident forms relating to the two bruising incidents could not be found in this person's care plan.

During the first day of our inspection we were informed by agency staff we spoke with that there had been three incidents involving people being distressed and showing aggression toward unfamiliar staff. Whilst we saw one incident had been recorded in the person's daily log the other two had not been documented. We checked with the permanent registered nurse who had arrived on duty and we could not find any incident reporting records of these events. This meant that an analysis of these events and any actions required was not undertaken. We noted the incident that was recorded was not a true reflection of events that had occurred. Records noted 'Not able to do personal care until 11. Became very aggressive, hitting out and shouting. Eventually washed and dressed'. The records did not state the possible reason for the person being aggressive. When we spoke with staff they felt the person had become distressed as they were unfamiliar to the person. In addition the records did not include that it had taken three people to undertake this care and how they had achieved this. This meant there was no opportunity to reflect on this situation and if there were any lessons to be learned.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by suitable staff who knew them well and were aware of their care and support needs. The number of staff employed were not adequate to cover all shifts and agency staff were used to cover any shortfalls. The service was staffed by a high level of agency staff. The agency staff told us that they had not read the care plans. Due to concerns raised regarding safe working practices the provider had taken the decision to remove the agency staff they currently employed. This had been done at short notice which did not afford a transition period for introducing new staff from another agency. Although a handover sheet was provided, this contained limited information. For example, one of the people referred to above, the information to agency staff was 'Challenging behaviour due to Alzheimer's and lashes out especially during personal care'. There was nothing documented on the handover sheet for the person giving the handover to alert agency staff to the type of behaviour the person might display and the support they may require. On the first day of our inspection the handover had taken place between all agency staff with no permanent staff present to give further detail of the information contained in the handover sheet. The agency staff we spoke with were not able to tell us about people's routines and preferences. When we

asked how they knew about people's care needs we were informed "We don't know who needs support or disturbing. We are just asking people". They had no information on when people liked to get up and the support they may require to do this.

Staff we spoke with didn't feel there was enough staff to support people to be able to get up out of bed or take part in activities. One member of staff told us "Mr X is not supported to get out of bed enough as he needs one to one support. There's just not enough staff". Another member of staff told us "A lot of people require two carers to assist them so there is no time to spend with people".
Another carer said "It can be quite difficult if you are the only permanent member of staff on duty and agency keep looking to me for support".

Comments from people and relatives about staffing included "I feel we have lost continuity of care with the agency going", "Staff are kind but they do change quite a bit" and "It's all strange faces which is confusing for him. There's a lot of agency so care is not a consistent as I would like".

We spoke with the regional manager about staffing arrangements. They explained due to the concerns raised regarding working practices the decision had been made the day before to remove the current agency staff and introduce another agency provider. In addition to agency staff they were using available staff from other locations within the organisation. They said they had brought in a manager from another home who was currently liaising with additional agencies to plan consistent staffing for the coming weeks. They assured us they had taken these measures to "Stabilise" the staffing provision with Fountain Place to ensure people were receiving appropriate care and support.

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

Staff told us they received training in safeguarding vulnerable adults and were aware of the different types of abuse people may experience such as verbal, physical or financial. Staff knew who they should report any concerns to and what actions to take should they suspect abuse had taken place. They said they would report their concerns to the registered nurse or senior worker. One member of staff told us "Safeguarding is about assessing risk and finding ways to prevent things from happening, such as abuse". The staff member felt that the culture on Fountain Place was one of being "Risk adverse". Staff said they would like to see more people accessing the communal areas but felt this did not happening because staff were worried people may fall.

Staff were not always confident that any concerns raised would be listened to and acted upon. One member of staff told us about an incident relating to poor working practices. They had reported this to the senior staff member on duty but did not feel they had received the appropriate support and information during this time. They had no information as to whether appropriate action had been taken to address the issue raised. We found no evidence in records that action had been taken by the senior management team to address their concerns. Despite this negative experience the staff member did tell us this would not put them off reporting any future concerns they may have. They said "I won't tolerate people being abused". One staff member told us "I don't have confidence with reporting things to senior management and don't feel they will do anything". Another staff member did tell us they had raised concerns about agency staff members' working practices and this had been addressed by the registered nurse. They told us those agency staff had not been allowed back to work in Fountain Place. During the inspection we identified at least three incidents where staff had raised concerns with regard to the conduct of other staff. We could find no evidence of the action taken by the management team in response to this whistleblowing.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service and relatives told us they or their relative felt safe living in the home. Comments included "I feel he is safe. I can raise concerns and do feel listened to", "I feel she is safe living here. She would tell us if something had happened", "I feel safe and comfortable with agency", "I feel very safe here; I'm glad I moved here" and "My family know I'm ok here". One staff member said "I do think people are safe here, day and night".

There were safe medicine administration systems in place. We observed part of a medicines round with an agency nurse, who had limited experience of working at the service, and was working alongside other agency health care assistant and one bank staff member who was also not familiar with people. Despite this, the agency nurse was professional and thorough when administering medicines. They checked the photographs on the medicines administration records (MAR) charts, and then asked people their names to ensure they were giving medicines to the right person. PRN (as required) protocols were in place and were detailed. For example, one person had a protocol in place for the use of analgesia (pain relief), which included information about where the person experienced pain and the reasons why. This meant people would get their pain relief in a consistent manner. We found for one person the dose to be administered differed between the prescribers instructions on the label and that recorded within the care plan. This was raised with the registered nurse in charge and they checked the correct dose and amended the instructions in the care plan. We saw that records showed the person had received the prescribed dose. One person using the service said "The nurses bring my tablets on time. I'm on pain relief and they make sure it's working for me".

Risk assessments were in place to support people to look after their own medicines. However for one person although there were records of his medicines having been received in the service there were no records to show when these medicines were supplied to him. This meant the service was unable to monitor his usage of these medicines. We spoke with the Regional Manager who agreed to address this immediately.

Medicines were stored safely. Fridge items were also stored correctly and had been labelled to indicate when they had been opened. The fridge temperature was being monitored daily.
When people were prescribed transdermal (skin) patches, there were records in place to show where patches had been placed to ensure they were rotated in accordance with manufacturer guidance.

Nobody was receiving medicines covertly or having their medicines crushed. Medicines were stored correctly and where required log books were completed in full with entries witnessed by another member of staff. Medicines that were no longer required were disposed of safely; these had been documented in the destruction book and again, the entries had been witnessed by another member of staff.

Topical medicines, such as creams, were applied by health care assistants but the MAR charts were signed by nurses. Health care assistants did not sign a chart to say when they had applied the cream. Some of the daily records contained staff documentation where they had written that creams and lotions had been applied, but this was not seen consistently. There were no body maps in people's rooms and so it was difficult to ascertain how agency staff would know which creams to apply, and the required frequency and location. One person visiting the service said "My relative has a sore bottom and a member of staff told me they thought the creams were not being applied every day as they should be which could be why it's still sore".

We observed that within the MAR chart folder that copies of the relevant medicines policy had been printed out but the date for review of these was for March 2015. When we raised this with the Regional Manager who was present on the inspection he told us the policies had been reviewed but not printed out which he would ensure was done. The provider had arrangements in place to monitor the competency of people administering medicines.

We saw safe recruitment and selection processes were in place. We looked at the files for four of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Inadequate

Is the service effective?

Our findings

People did not always receive effective care from staff who had the knowledge and skills needed to carry out their roles and responsibilities. The high amount and limited continuity of agency staff being used meant agency staff had limited knowledge about the needs of people using the service. Agency staff told us that whilst they knew care plans were in place they did not have the time to read them. For example, when a bank member of staff approached an agency nurse to ask for a handover, the agency nurse was unable to provide any information. They told us this was because they had not been provided with any. One person using the service said "I'm not sure if the staff know what support I need, but we just get on and do it".

The concerns raised with us contained issues about how new staff were inducted when they commenced employment. We asked to see the records relating to staff induction. The documentation related to all three locations and showed that not all staff had received a full induction when they commenced employment and some records for some new staff were missing. The documents that we were given did not contain any evidence that new staff completed or had enrolled on the Care Certificate. We asked the managers, who were available on the day of the inspection, about the missing documents but these could not be found and the managers could not confirm if the induction for all staff had been completed.

The Nominated individual told us that there was not a policy relating to the induction of new staff. They told us that new staff induction was managed at a local level and although it was expected that new staff would complete a two week induction this would be dependent on the staff member's previous experience and skills. The senior management could not confirm what proportion of the induction would be face to face learning, computer based learning or shadow shifts. The Nominated individual told us that in response to the concerns raised a formal induction policy was being developed.

We spoke with agency staff during two days of the inspection. They said they had not received any induction or information, only a brief handover. On day one this handover had contained minimal information as it was conducted by agency staff to agency staff. We did observe the information in the handover was much more comprehensive on day two, when the registered nurse conducted it. Comments from agency staff included "No I did not have an induction. I have not really received any information. I don't want people to be at risk so I am asking for support" and "I haven't worked here for a while. I didn't get an induction. I didn't know who was on food and fluid charts. We have had to work it out and ask people what they want. I don't know the staff I am working with. Next time I will know how to organise the shift".

The concerns raised with us contained issues with regard to staff training. We asked to see the records relating to staff training. The records we looked at contained information for staff at all three locations. We looked at the records with one of the senior managers. The records were chaotic and did not contain information relating to all staff training. The senior manager agreed with this view. We asked to see a training matrix to confirm what staff had completed training to ensure that they had the skills and competencies to fulfil their roles. The training matrix was not available and the senior manager could not confirm if one was in place. The deputy manager who was available on the second day of our inspection visit could also not confirm if a training matrix was in place.

We spoke with one permanent registered nurse on duty and the deputy manager/clinical lead for the service. Both nurses said they had received the training necessary to do their role. For example, the nurse said they had received training specific to their role such as tissue viability, end of life and syringe driver use. The clinical lead said they had been reviewing the training provided for health care assistants; for example they said they were reviewing the manual handling training provider and were exploring train the trainer roles and link roles for junior staff in order to provide them with more skills and experience.

There was a lack of opportunity through staff supervision to review individual personal development and progress. We requested a copy of the supervision timetable for 2015 and 2016 for all staff, one was not provided to us. We looked at the documentation relating to staff supervision. Across all three locations 45 to 50 staff were employed. Of these only nine staff had received supervision in 2016. Only four staff had received an end of year appraisal.

When we spoke with staff, they told us they had not received regular supervision meetings with their line manager. These meetings should be an opportunity for staff to discuss progress in their work; training and development opportunities and other matters relating to the provision of care for people living in the home. These meeting would also be an opportunity to discuss any difficulties or concerns staff had. One member of staff told us "During the supervisions I have received I have made suggestions to improve things but nothing has happened". Another member staff said "I don't feel supported. The last supervision I had was four or five months ago. The registered nurse said they had received a supervision session "earlier this year" and were due their annual appraisal the week of the inspection.

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

It was not always clear if people had been supported to have sufficient to eat and drink throughout the day. The systems in place for monitoring people's food and fluid intake were not robust. The service had been using an electronic system for staff to document what people had to eat and drink. However, the system had not been working for two days prior to the inspection and although people had paper records in place, these indicated that people's intake was not being sufficiently monitored. For example, one person had three records of their fluid intake for the same day. On the 17/05/2016, staff had documented on three different charts that the person's total intake for the day was 900 mls, 1100 mls and 1500 mls. It was not clear which, if any record was accurate. We showed this to the Clinical Lead who was unable to say which record was the correct one. The fluid charts that were in place for people did not have a target recorded, although the care plans did contain a daily target. Despite the daily target in the care plans, it was not clear how the daily intake was monitored by senior staff, or how concerns in relation to poor fluid intake were escalated.

One person was having their fluid intake monitored and the care plan informed staff to provide high calorie drinks and supplements and to 'assist/prompt' the person. The daily fluid intake target in the care plan was 1200mls per day. However, the fluid charts in relation to this person showed that on 16/05/2016 they had 1350 mls, on 17/05/2016 they had 550 mls and on 18/05/2016 they had 950mls. There was nothing documented within the daily record to indicate whether staff had identified the poor fluid intake on 17/05/2016. Another person's care plan had a daily target intake of 2100 mls per day. However, the fluid chart for 18/05/2016 showed a total recorded intake of 450 mls. Again, there was nothing documented to indicate if the poor intake had been identified by staff and any action taken

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There was a risk that people were not always being assessed for specialist nutritional and dietary needs. In addition, there was a risk people were not always receiving food and/or fluid at the correct consistency because of the conflicting information provided to staff. When people had specific dietary or nutritional

requirements, information was not always clear or available to staff, and on two occasions the information provided was contradictory. For example, in one person's care plan staff had completed a choking risk assessment on 26/02/2016. The person had been assessed as 'high risk'. The risk assessment guidance listed the required actions as 'consult SALT (speech and language therapy team). Clear guidelines must be included in the care plan. All staff to be made aware of action to be taken in case of choking'. However, there was no care plan in place in relation to the risk of choking. The eating and drinking plan stated the person should have a liquidised diet and 'two scoops of thickener'. There was no evidence of any SALT referral having been made. The handover sheet provided to staff stated the person was receiving a 'Type C thick pureed' diet, but it was unclear how this decision had been reached without specialist input. When we discussed this with the registered nurse they said the person was having only 1 scoop of thickener in fluids and not 2 as documented in the care plan. We observed this person being assisted with their lunch by the Activities Co-ordinator. We observed them having to pat the person on the back during the meal. We asked if they had been trained on how to deal with someone who was choking and they said "I've had first aid training, but it's quite difficult when someone's in bed. I'd call the nurse for help".

When we asked the nurse about SALT assessments, they showed us an email from the SALT team which stated nursing staff were able to add thickener to people's drinks based on their own professional knowledge. The email was dated 30/12/2015 and also offered staff the opportunity to access training in relation to this, but this offer had not been taken up. This suggested that nursing staff may not have been fully trained to assess and support people who might require the addition of thickeners to their drinks.

The handover sheet provided to agency staff, noted another person was receiving a 'Texture E diet'. However, staff had documented within the person's care plan that they were on a 'normal diet'. When we asked the Clinical Lead about this, they said the person chose to have a Texture E diet; however, this information was not written within the care plan for staff to be aware of the person's choice. In another person's care plan, it was documented that they should receive 'thickened fluids to a syrup consistency' and they had been assessed as a high risk of choking. However, a letter in relation to the person's discharge from hospital on 10/07/2015 it stated the person had been assessed by the SALT team during their admission and was to receive a 'normal diet'. Again, it was unclear which information was most up to date.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service and relatives spoke positively about the food choices. One person said "I more or less enjoy everything, there's always enough to eat". However, they also added "The food is not always as hot as I would like". Another person told us "The food is very nice. They are trying to feed me up as I have been losing weight". Other comments included "There is always plenty of food and drink", "I have no complaints about the food. I am having turkey today" and "The foods not bad it's improved a lot". During the inspection, we observed two people using the service eating their lunch in the dining room. Everybody else ate in their rooms. One person said "Sometimes I go down to the dining room, but I usually stay and eat in my room".

People had access to specialist diets when required for example pureed or fortified food. We spoke with the catering staff; they had information of all people's dietary requirements and allergies. This also included people's likes and dislikes which staff would let them know each day. They explained that people had a choice of meals. Meal choices were made the day before and this information was given to the catering staff. They said if people did not like what was on the menu or had changed their mind about their choices then they were able to request alternatives. We asked about how they ensured people received the meal of their choice and how portion size was controlled. They explained they would always send enough food for the

requested meals. For example they would ensure that if five portions of turkey had been requested then this would be catered for. We explained about a person we had been talking to that morning and how they had requested a turkey lunch. However when we spoke to them about this they said they had not received their requested lunch and been given the alternative which they said "Wasn't nice". We had spoken to staff to ask why the person had not received their chosen meal and were told it was because they had run out. We asked why, if the person had made the request, it was not provided and they did not know. The catering staff explained that staff could ring them if portions were missing and they would have provided the person with their chosen meal.

The kitchen was clean and tidy and had appropriate colour coded resources to ensure that food was prepared in line with food handling guidance. The kitchen had been award a Food and Hygiene rating 5 by the food standards agency. The food standards agency is responsible for protecting public health in relation to food in England, Wales and Northern Ireland.

People's health needs were monitored. They were supported to maintain good health and receive ongoing healthcare support. People spoken with confirmed staff supported them to see their doctor when they felt unwell. Care plans confirmed people had access to health care professionals as required such as a GP or consultant specialist. Visits from health care professionals were recorded and any outcomes of these visits.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found people's consent to care and treatment was not consistently sought in line with the MCA 2005. Where people had the capacity to consent to their care and treatment, the consent was not recorded. Mental capacity assessments were completed for people who lacked capacity to consent to their care and treatment. These were not always decision specific and it wasn't always clear who the decision maker was. The provider had contacted the Office of Public Guardian confirming who had a registered Power of attorney for supporting people in making best interest decisions. We found staff lacked understanding of the difference in decision making for Health and welfare Power of Attorney or Finance and Property. Some people's care records had copies of Enduring power of attorney, which only gave power for decision making around finances and property. However we found staff had been consulting with relatives with an Enduring power of attorney, making decisions around health and welfare, such as end of life care plans, flu vaccinations and do not attempt resuscitation (DNAR).

Mental capacity assessments around decisions for consent to care plans such as personal care and day to day decisions were completed by staff, without consultation with the legal representative. Some mental capacity assessments were incomplete with no date and no signature. Best interest decisions where people lacked capacity to make a certain decision, was not clearly recorded.

The registered manager had made applications for DoLS authorisations as required. Applications had been

submitted to the Local Authority Supervisory body and they were awaiting a response. We found where people were still waiting for an assessment to authorise their deprivation of liberty, that the least restrictive options in their care plan had not been considered. We found the following statement in people's care records "Less restrictive treatment and measures cannot be provided due to declining dementia."

This was in breach of Regulation 11 of the Health and Social Care Act (2008) Regulations 2014

Staff demonstrated a good understanding of supporting people to make choices and decisions about their daily living. Staff said people were always offered the choice of when they wanted to get up or go to bed, what they wanted to eat and drink and how they wanted to spend their day. One staff member said "Choice is about respecting people's wishes, beliefs and preferences and should be recorded in people's care plans". Another member of staff said "You should never assume you know people's choices, you should always ask them".

Requires Improvement

Is the service caring?

Our findings

Permanent staff were aware of people's individual preferences, likes and dislikes. However because of the high use of agency staff, staff did not know the people they were supporting. On the first day of our inspection we saw that all the staff on duty that day were agency staff who had worked only one other day at the service previously, and for some it was their first day. Agency staff did not have the time to read the care plans, which meant they did not always know the people they were caring for, including their preferences and personal histories. For example, in one person's plan, within the personal hygiene section, it was written that they preferred female staff. On the first day of the inspection we observed a male member of agency staff assisting a female member of agency staff with the person's personal hygiene needs. Due to the high use of agency staff care was organised and delivered in a task focused way rather than person centred. For example, one member of agency staff said they had approached a permanent member of staff to assist them to reposition a person. They said they had been told that two other members of staff were "doing the turns". This meant the person was not moved when they requested but when it was their turn on the list.

On the first day of our inspection we observed staff attempting to assist one person with their personal care needs. This person was being resistive to care. We heard, through the door, staff explaining to the person what they were trying to do but the person was not cooperating. They tried to distract the person by talking about a relative who was due to visit but this did not work. We spoke with the agency member of staff when they came out of the person's room and they explained the person was refusing care and they were trying to encourage them because the person's continence aid needed changing. There were two staff trying to support this person who both stated they did not know the person. Eventually the registered nurse, whose day off it was, was called in to the home to attend and support the situation. At this point the other staff member stated "We will have to leave them in a mess until (registered nurse) comes in. It's their choice as they are not happy and are being aggressive". They stated to us "I have come into cover but I don't know people". Eventually all three staff on duty attended to support this person. The agency staff explained that one of the other agency staff had been working in the home the previous day and was therefore slightly more familiar to this person and had been able to talk with them whilst the other two staff were able to wash and dress them. We looked at this person's care plan which clearly stated this person could be resistive to care if a new member of staff they were unfamiliar with attended to their personal hygiene needs. On this occasion there were two unfamiliar staff who were not aware of this.

One the second day of our inspection we spoke with the registered nurse about this person's needs and they told us the person had been supported to get up that morning with no "Problems" due to having familiar staff available. However when we went to speak to this person and their relative later in the morning, 11.30, their personal care needs had not been met. The staff had only supported the person to get out of their bed and into their chair. When we looked at daily records we could not see any evidence of personal care being provided. The last entry which identified personal care had taken place was recorded in the afternoon of the previous day. Night time observations only recorded 'X was well most of the night' but there was no record of personal care being provided. This meant there was no evidence the person had received any personal care since the day before. We spoke with the registered nurse about our findings and they supported the person to receive their personal care immediately.

Agency and bank staff were given an 'Agency information sheet' which provided an overview of people's mobility, nutritional and personal care needs. When observing the staff handover on the second day of inspection it came to light that staff on our first day had not been able to locate the hoist required to move people who required it. We asked the agency staff member how people had then been afforded the choice if they wanted to get out of bed. We were informed this had not been an option for people on the first day of our inspection.

We asked staff and the registered nurse about one person who we had observed to be in bed and there was no medical reason for this to happen. They explained this person needed 1:1 support to get out of bed and they were concerned they may slip down whilst sitting in their chair. They stated the person was able to sit in a chair when they were "Calm". We could find nothing in this person's care plan that had looked at ways of supporting this situation to allow the person to get out of bed should they wish to. We spoke to staff on both days about how often they offered this person the opportunity to get out of bed and was it part of their day to go and do this. Both staff stated they did not go and ask this person if they wanted to get up due to a lack of staffing. Both staff felt this person should be offered the opportunity to get out of bed more often. One of the staff members told us the person had recently attended an activity in the lounge area which they had enjoyed.

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

We were limited in our observations of care practices due to most of the people living at Fountain Place spending time either in their rooms or in bed. When people were overheard calling out or becoming distressed, the staff on duty, both agency and permanent staff responded quickly to relieve any distress. For example, we overheard one person ask to have their top changed. When the agency staff went to pull the curtains in their room, they began shouting and asking what they were doing and why. The agency member of staff responded with "I'm just pulling the curtains to while we change your top if that's ok. It's so people can't see you getting undressed".

We observed people's privacy and dignity was upheld. Personal care took place behind closed doors. We observed staff knocking before they entered people's rooms. One person said "My door is usually open throughout the day, but staff always knock before they come in. If they are helping me with personal care, they close the door and they always respect my dignity". The same person said "Staff always ask my permission before doing anything for me. I like to relax in the bath or the shower, and if I ask, they always leave me there for a bit, and then come and help me when I call them". Staff told us when supporting people with any personal care they would always ensure this was done with the person's door closed. They said they would encourage the person to do as much for themselves as they could. They said they would always ensure that people were covered when supporting with intimate tasks. One staff member said "I treat people how I would want my family member to be treated. I'll check what I'm doing is ok and explain what I am doing".

We saw staff supporting one person to go from their bedroom to the bathroom to have their personal care needs met. Staff provided a blanket to preserve the person's dignity as they were in their nightwear

People spoke positively about staff and told us they were kind and caring. Comments included "Staff have never been unkind to me. We all get on alright"; "Staff are all kind and helpful. I really admire what they do. It's not an easy job" and "It's excellent here. The care is good". One relative told us "I feel permanent staff know him well and he is fine with them. I don't feel agency staff know his routines".

Visitors were able to visit whenever they wished. One person said "My relatives can come and go as they please". They also said "I'm very settled and happy here. I have a decent sized room with an ensuite". Relatives told us they were welcome anytime. One relative said "Staff are always chatty and welcoming".

According to the staff handover sheet, one person was for end of life care. However, the End of Life plan contained minimal detail. Staff had documented the person 'would like to be kept pain free and comfortable in the last stages of life'. Although the pain relief section of the plan described where the person experienced pain and listed the prescribed analgesia, there was no other detail documented. The person also had breathing difficulties and slept with their mouth open. This causes a person's mouth to become dry and uncomfortable, but there was no plan in place to inform staff how to provide oral care to keep the person comfortable. Staff had liaised with the GP to discuss whether the person's current pain relief prescription was adequate. These discussions had been documented within the plan.

Requires Improvement

Is the service responsive?

Our findings

People did not receive personalised care that was responsive to their needs because care plans were not person centred. For example, One of the care plans we looked at contained detailed personal preferences. These were located at the front of the person's care plan; however, the information was out of date and did not reflect the person's current care needs. In addition, the information documented was contradicted throughout the care plan. For example, the personal preferences information contained a statement "Likes a bath/shower twice a day". Within the personal hygiene section of the plan this was contradicted as staff had documented "Likes a full body wash daily and a shower once a week".

In another person's plan a DoLS application had been submitted in October 2015 and stated the person required a pureed diet to help sustain their weight and had no choice about this. On the agency handover sheet it stated the person required a 'soft, fork mashable diet'. However in the person's eating plan dated January 2016 it stated the person had been assessed by Speech and Language Therapy (SALT) as requiring a normal diet and need support to cut up their vegetables and meat.

Several people were observed throughout the inspection being nursed in bed, but it was not clear why this was required. One person remained in bed throughout the inspection and staff said this was because they needed 1:1 supervision when they were sat in a chair. Although staff were understandably busier during the morning, the person was not encouraged to sit out of bed during the afternoon when more staff were available to support them.

Another person was described as 'Immobile" and "nursed in bed' on the handover sheet. It was written on the sheet 'Unable to sit out due to dislocated hip'. However, when we looked at the person's care plan, this information did not correspond with what was within the plan. The person had been discharged from hospital following orthopaedic surgery during July 2015. The discharge summary letter within the plan dated 10/07/2015 informed staff "Post op instructions allow full weight bearing" and 'Transfers into the chair with the assistance of two'. There was no mention of a dislocated hip within the care plan and there was no documented medical reason for why the person needed to be nursed in bed. Within the skin integrity section of the plan, it had been documented on 11/02/2016 'Nursed in bed on air mattress due to very high risk of pressure sores'. The person had been assessed as high risk, but their skin was intact. Within the same section of the plan, it had also been documented 'If wants to sit out in chair, ensure pressure relieving cushion in place'. We showed the plan to the Clinical Lead and asked why this person was being nursed in bed. They said they were unsure and that the person had been bedbound when they commenced their employment three months earlier. We also asked staff why this person was nursed in bed and they stated "They have always been in bed. I don't know". We asked the registered nurse why this person was in bed and they told us the person had refused when they asked if they wished to get out of bed. We could find no information as to what had been done to support or encourage the person to maintain their mobility. The only information available was a review held in October 2015 which stated 'Nursed in bed' but no information as to why.

When people had been assessed as being at high risk of pressure ulceration, care plans provided some

guidance to staff on how to prevent this happening. However, the information was limited. For example, care plans referred to air mattresses being in place and informed staff to "ensure equipment is in full working order". The service was using different types of air mattresses. Some of these had weight specific controls for staff to set. Other mattresses had settings of high, medium and low. None of the care plans informed staff which setting the mattresses needed to be at. We looked at four air mattresses that were in place. One person whose weight was recorded as 70kg had a mattress set for a weight of 100kg. One person whose weight was recorded as 56.8kg also had their mattress set at 100kg. Another person whose weight was recorded as 46kg had a mattress set at the highest setting. One other person whose weight was recorded as 83 kg had a mattress set at the medium setting. Having air mattresses set at the incorrect pressure can reduce their effectiveness and cause discomfort for the person using them. As two of the mattresses did not have controls that showed which setting should be used for which weight, we asked to see the manufacturer manuals so that we could check the mattresses were set correctly. However, neither the nurse nor the clinical lead were able to show us where these were kept. Although the nurse adjusted the settings on the mattresses, there was no process in place for staff to check the settings regularly. The lack of availability of the manufacturer manuals meant neither we nor the nurse in charge were able to confirm if the mattresses were set correctly. In one other person's care plan it was documented on 19/03/2016 that they had an air mattress in situ; however, when we checked, there was no air mattress in place. We asked the Clinical Lead if the person should have one in place and they were unsure.

In addition to the use of air mattresses to prevent people from developing pressure ulcers, care plans also instructed staff to ensure people were repositioned regularly throughout the day and night. All of the people who were at risk of pressure ulceration had plans in place which told staff that two hourly position changes during the day and four hourly during the night were required. The records in place to evidence people had their positions changed in accordance with their plans were limited and did not demonstrate that care had been delivered as planned. We looked at the electronic records of 11 people for the week prior to our inspection. Of these four people were nursed in bed during our inspection. On 12/05/2016, the records showed that one person had their position changed once during the day. Three other people had their position changed three times. On 13/05/2016 the records showed that one person had their position changed twice, one person five times, one person twice and one person once.

Because the electronic system of recording was not working we looked at the paper records for position changes for the days prior to our inspection and the days of our inspection. When we looked there were no records completed and there were no charts in place for staff to complete. We discussed this with the registered nurse during the afternoon of day one of our inspection and they said they would ensure they were put in place. On the second day of the inspection we saw that position charts were in place for people and they were being completed. However, these did not always reflect the guidance within the plan. For example, one person's position chart had been completed at 02.00hrs, 04.00 hrs, 06.00 hrs and 12.30 hrs. This meant the person had remained in the same position for 6.5 hours, when the care plan stated they should have their position changed every two hours.

It was also noted that charts for the previous day had been completed retrospectively, including the timings for when staff had changed people's position. It was difficult to assess whether these charts provided an accurate record of events; one member of agency staff who had been on duty the previous day was unable to confirm if the timings were accurate. They said "They (people) were not moved as frequently as the charts say".

Care plans provided limited detail for staff to follow. For example, in one person's plan staff had documented that they had 'limited verbal communication'. Staff were informed to 'read body language and facial expressions', but there was no detail of what type of body language or facial expressions the person

might display which meant staff, particularly those who were unfamiliar with the person, would not know what the person was trying to convey.

Care plans had been reviewed on a monthly basis, but the conflicting information we saw had not been noted by staff completing the reviews. Relatives of people using the service had been invited to participate in care plan reviews and we saw records that showed these had taken place approximately every six months.

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

We spoke with the activity coordinator who was responsible for organising activities for people to take part in. There was a general activity programme in place which included a visit from the Pets AS Therapy (PAT) dog. The coordinator explained it was difficult to plan activities for people as they were either in bed or chose to stay in their rooms. They said planning of activities was flexible and they tended to plan on a daily basis. We asked what activities were provided on a 1:1 basis for people who were in their rooms. They told us they spent time getting to know people by chatting with them. They also read to people if they wished or watched a television programme with them. They said they had done some origami with one person. However there was not a programme of activities set up for individual people based on their past interests or hobbies. During our inspection we observed there were not enough meaningful activities for people to access in groups or as individuals to avoid social isolation.

Staff we spoke with felt people could be encouraged to leave their rooms more or to get out of bed. We did not observe or read in people's daily notes that staff had tried to encourage people to get up or do something that was related to their interests. Comments from people included "The activities coordinator will get me books", "I don't believe in the activities so I don't join in" and "I wouldn't mind a trip to see the trains". When we asked about day trips staff told that people mostly went out with their families. The activities coordinator said now that the weather was getting nicer this was something they would be looking into.

There was a procedure in place which outlined how the provider would respond to complaints. People told us they knew what to do if they were unhappy with any aspects of care they were receiving. They said they felt comfortable speaking with the registered nurse or a member of staff. Comments included "I would speak to staff but I've never needed to complain", "I'm happy with my care. I have no complaints" and "I have no concerns or worries. If I had any concerns I would talk to staff". A relative told us "I can raise my concerns and they do listen and take actions". One person using the service said "I've never had to complain, and I wouldn't know how to or who I need to speak to. I would speak to my family and ask them to sort it". They also said "I don't think I've ever been asked to complete a survey".

Inadequate

Is the service well-led?

Our findings

The registered manager was not present during the inspection; however, members of the senior management team including the nominated individual, a regional manager from another area, a newly appointed regional manager for the Wiltshire area and a home manager from another area were present.

We found that there was a lack of quality auditing and governance processes. The lack of clear quality auditing process had not informed the senior management team including members the board and nominated individual of the concerns identified in this report nor were they aware of the whistleblowing and safeguarding concerns that staff had raised. As a result no actions had been taken to assess, monitor, mitigate risks and improve the quality of the service. Limited action had been taken to address shortfalls identified in previous CQC inspection reports and to prevent the reoccurrence of issues.

During the inspection we asked the Nominated Individual to explain how the service was monitored. The Nominated Individual told us that the registered managers of services were responsible for conducting a range of audits which were then sent to the Quality and compliance manager. The Quality and Compliance manager then highlighted any trends, patterns or issues and these were reported to the senior management team at board level. In addition to this Area Managers completed a monthly visit to each service to assess the quality of care and to complete additional audits. Records of these monthly visits were also sent to the Quality and compliance manager for review and formed part of the report sent to the board. We were informed during the inspection that the quality and compliance manager had been off sick for a period of time

We found some audits had been completed by the registered manager and these included audits relating to infection control and medicines. However when we asked to see audits relating to staff induction, staff supervision, a staff training matrix and a dependency tool used to determine safe levels of staffing (this had been completed by the second day of our inspection) and audits relating to care planning these were not available. We asked to see how the service had gained the views of people using the service, their relatives and other professionals we were told that surveys had been conducted but these "could not be found".

We saw a range of meetings had taken place with relatives, people who used the service and staff. These meetings had taken place in January 2016. The relatives meetings raised some issues including lack of activities and stimulation for people, a lack of staff presence in communal areas, and ongoing issues with staff recruitment. At the staff meetings discussions took place between the manager and staff asking what action had been taken since the last CQC inspection. Not all staff had read the CQC report and so were not aware of any improvements that were required.

In addition concerns were expressed by the manager that he was not receiving accident /incident and safeguarding reports. The minutes of the staff meeting state "I am receiving less forms each month but this is not due to less incidents" and "as with the accident forms all safeguarding issues must be reported to x at the time of the incident along with the completed form". We asked to see an action plan as to how concerns raised at the meetings were going to be addressed. We were told that one was not available. The senior

management team, who were available on the day of the inspection visits, could not assure us and were not aware of the issues raised at the meetings nor were they aware of any actions that had been taken to address these concerns.

During the inspection we reviewed the records relating to staff supervision. Only nine staff of the 45-50 staff employed had received supervision across all three locations from January to May 2016. We reviewed all nine supervision records. Of these three raised concerns with regard to the conduct of other staff or issues with performance. In addition during the inspection one staff member told us that she had raised concerns with regard to the conduct of another staff member. We reviewed the personnel files for all of these staff and could find no evidence of any action being taken including disciplinary action or increased supervision. The managers available on the inspection visits were not aware of these issues or of the actions taken in response to this whistleblowing.

During the inspection we saw a memo from the manager to staff dated 5 April 2016. The memo raised concerns that meals prepared for people were being taken by staff. The manager had highlighted that this was not acceptable and was to stop immediately. When we asked the senior management team they were unable to tell us if this remained an issue and what action had been taken to prevent it happening again.

We asked to see the records relating to the providers monthly visits. The folder we were given contained provider visits for the October, November and December 2015 and April 2016. We asked the regional manager and Nominated individual for the documentation relating to the visits for January, February and March 2016. These could not be provided. The provider visit forms which we saw had not identified any of the concerns highlighted in this report with the exception of the ongoing issues with staff recruitment.

During the inspection we spoke to the Nominated Individual who stated that whilst he was aware of issues with regard to retention and recruitment of staff and that the locations were not the "best performing homes in the group" he was not aware of the whistleblowing concerns, the lack of ongoing supervision of staff, issues relating to staff induction and training, the lack of accidents and safeguarding forms or the issues highlighted in the memo to staff. The Nominated Individual confirmed that no action plan, that he was aware of, had been developed in response to these concerns. The Nominated individual confirmed that the quality and compliance manager was off sick and had been for some time. They agreed that the lack of safeguarding and incident/accidents reporting should have been considered a risk and should have warranted further investigation. When we asked them if they felt that their oversight of the locations seemed overly reliant on one person and if that person was not available then the system did not appear robust, they agreed.

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

We spoke to the nominated individual about the concerns that had been received and any action that had been taken in response to this to keep people safe. The nominated Individual told us that a number of staff had been suspended pending a full investigation. Following this any disciplinary action would be taken if this was required. Retirement Villages were developing a formal induction policy and would review the training provided to staff. The current Registered Manager was unavailable and so an interim manager was been sought to commence employment as soon as possible and in addition the senior management team would have a presence at the services for as long as required.. The nominated individual provided assurance that they would work with both us and the local safeguarding team to ensure that any remedial action or improvements would be implemented as a matter of urgency. Following the inspection we formally wrote to the provider to seek these assurances. The provider confirmed this and agreed that the home would not

consider any additional admissions to any of the three locations until such time as the safety of people at the service could be assured.

The people, staff and relatives we spoke to told us that they felt that the registered manager was approachable and was working hard to improve the standards of care at the service. As the registered manager was not available we were unable to discuss with them their views on the concerns raised or how they hoped to develop the service in the future.

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 9 HSCA RA Regulations 2014 Person-centred care At the time of our inspection the service was using a high amount of agency. As agency staff did not have time to read care plans people were at risk of receiving care from staff who were not aware of their personal preferences and did not know their care and support needs. Care and treatment was not always planned to ensure people's needs were met. People's care plans did not always contain the most up to date information to enable staff to be responsive to people's needs. Information within c

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent We found people's consent to care and treatment was not consistently sought in line with the MCA 2005. Where people had the capacity to consent to their care and treatment, the consent was not recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment It was not always clear if people had been supported to have sufficient to eat and drink throughout the day. The systems in place for monitoring people's food and fluid intake were not robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place to effectively investigate when concerns around poor practice with staff were raised. We could find no evidence of the action taken by the management team in response to whistleblowing concerns raised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People did not always receive effective care from staff who had the knowledge and skills needed to carry out their roles and responsibilities. Staff did not receive appropriate training, supervision and appraisal to enable them to carry out their duties.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from the risk of harm. Whilst risks were identified, people's care plans did not always contain guidance for staff on how to minimise the risk. Accidents and incidents were not always recorded appropriately and reported to the management team for investigation and follow up actions where necessary.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Problems with the service and required improvements were not always identified. We did not always see evidence of actions taken where concerns had been highlighted.

The enforcement action we took:

Positive condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not always supported by suitable staff who knew them well and were aware of their care and support needs. The number of staff employed were not adequate to cover all shifts and agency staff were used to cover any shortfalls.

The enforcement action we took:

Warning Notice