SPV4 Limited

The Fountains Nursing Home

Inspection report

Victoria Park
Swinton Hall Road, Swinton
Manchester
Lancashire
M27 4DZ

Tel: 01617945814
Website: www.thefountains.care

Date of inspection visit:
30 May 2018
01 June 2018
04 June 2018

Date of publication:
09 August 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 May and 1,4 June 2018. The first day was unannounced, however we informed staff we would be returning for a second and third day to complete the inspection and announced this in advance.

The Fountains Nursing Home is owned by SPV4 Limited . The home is situated in large grounds overlooking Victoria Park and is close to Swinton town centre. The home provides both residential and nursing care for up to 98 people who require personal care for both physical and mental health related illnesses. The home consists of four units, known internally as Victoria (General Nursing), Lowry (Nursing Dementia), Garden Rooms (General Residential) and Park View (Residential Dementia). At the time of the inspection there were 89 people living at the home.

The Fountains Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

This was the first inspection we had carried out at The Fountains Nursing Home, since the provider, SPV4 Limited purchased the home and registered with CQC in October 2017.

During this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to person centred care, safe care and treatment, safeguarding people from abuse and improper treatment, good governance and staffing. We have also made a recommendation regarding responding to information received in satisfaction surveys. You can see what action we have asked the home to take at the end of this report.

People living at the home did not always receive their medication safely. We found two instances (one on Park View and one on Garden Rooms) where staff had signed on the medication administration record (MAR) that medicines had been given, however the medication was still in the blister pack. Drink thickening supplements such as thick and easy were not stored securely and were accessible in cupboards on Park View unit and could place people at risk of harm.

People were placed at risk of skin break down because equipment such as pressure relieving mattresses were not at the correct settings. This was predominantly on Victoria unit.

We noted several environmental risks, again on Victoria unit, which could place people at risk. These included sluice room doors being left unlocked with keys in the door, meaning cleaning products could be accessed and place people at risk of harm. Areas of concern identified during the last fire risk assessment were not being acted on and we observed fire doors being held open with a drinks trolley and wedged with people's slippers. This meant the door would not close properly in the event of a fire. Corridors on Victoria unit were cluttered with hoists and wheelchairs and could affect people's exit in an emergency situation.

People living at the home said they felt safe and staff had a good understanding about how to safeguard people from abuse. We were informed about one incident where a member of staff had reported concerns to the manager about how another member of staff had behaved towards a person living at the home, as they felt this was being done in a threatening manner. This had not been reported as a safeguarding incident to the local authority. This was subsequently sent following our inspection.

We found there were not enough staff deployed to effectively meet people's needs on Park View Unit, particularly at meal times. We observed staff were unable to assist people with tasks such as mobilising around the unit due to supporting people who needed full support to eat and drink.

We looked at the safety and suitability of the premises. A refurbishment plan was in progress at the time of our inspection and we observed several of the units had new carpets, chairs and window frames. The Lowry unit was still in need of refurbishment in many areas and we will monitor the progress of this work at our next inspection to ensure it has been carried out in line with the set time scales.

Effective systems were not always in place with regards to deprivation of liberty safeguards (DoLS) and the Mental Capacity Act 2005 (MCA).

People told us they received enough to eat and drink and we observed people receiving appropriate assistance from staff during the inspection at meal times. We saw people had been appropriately referred to services such as speech and language therapy (SALT) and dieticians if their were concerns about their nutritional status. Advice and guidance was not always well recorded however, such as if people had received prescribed supplements or milky drinks to help them maintain a healthy weight.

People did not always receive care that met their needs outlined in their care plan.

Accurate and contemporaneous records were not always being maintained in relation to people's care needs.

We have made a recommendation within the detailed findings of the report about ensuring information from satisfaction surveys is acted upon and clearly documented.

Audit and quality assurance systems were in place, however needed to be improved to ensure concerns found during this inspection were identified and acted upon in a timely manner.

Some of the feedback we received from staff was that they felt management and nursing staff were not supportive and approachable.

Staff were recruited safely, with appropriate checks carried out before they commenced employment.

Safety checks of areas including electrical installation, gas safety, legionella and hoists had been carried out, with any remedial work/recommendations acted upon.

Staff told us they received sufficient induction, training and supervision to support them in their role. Appraisals had not yet been carried out under the new provider and we were told these had been scheduled to be completed following our inspection.

People living at the home told us they were happy with the care they received, as did any visiting relatives we spoke with. People said they felt treated with dignity, respect and were given privacy when they needed

it.

Complaints were handled appropriately, with a response provided where people had expressed any concerns about the service provided.

A range of different activities were available for people to take part in if they wished.

Meetings took place for staff, people living at the home and relatives so they could discuss and contribute towards the running of the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

Medication was not always stored and given to people safely.

People were placed at risk of skin break down because their pressure relieving mattresses were not at the correct setting.

Several environmental risks were seen on Victoria Unit.

Sufficient numbers of staff were not effectively deployed on Park View Unit.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Appropriate systems were not in place regarding the management of DoLS and the MCA.

People said they received enough to eat and drink, however advice from dieticians was not always recorded.

Staff received the appropriate induction, training and supervision to support them in their role.

Is the service caring?

Good

The service was caring.

People who lived at the home and visiting relatives made positive comments about the care being provided.

People were treated with dignity and respect and had their independence promoted by staff.

We observed caring interactions between staff and people living at the home.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

People did not always receive care in line with their assessed needs and preferences.

Accurate and contemporaneous records were not always maintained by staff.

A range of activities were available for people at the home if they wished to participate.

Complaints were handled appropriately.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

Improvements were required to governance and quality monitoring systems to ensure concerns from this inspection were identified and acted upon in a timely manner.

Some of the feedback we received from staff was that management and nursing staff were not always approachable and supportive.

Team meetings took place so that staff could discuss their work and raise any concerns.

The Fountains 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.

This inspection took place on 30 May and 1,4 June 2018. The first day was unannounced, however we informed staff we would be returning for a second and third day to complete the inspection and announced this in advance.

The first day of the inspection was carried out by two adult social care inspectors from the Care Quality Commission (CQC) and an expert by experience. An expert by experience is someone who has personal experience of caring for people with needs similar to those living at The Fountains Nursing Home. The second and third days of the inspection were carried out by one adult social care inspector only.

Prior to the inspection we reviewed all of the information we held about the home in the form of notifications, previous inspection reports, expected/unexpected deaths and safeguarding incidents. We contacted Salford city council before our inspection to establish if they had any information to share with us. This would indicate if there were any particular areas to focus on during the inspection.

During the inspection we spoke with a wide range of people and viewed documentation relating to how the home was run. This included speaking with the registered manager, regional manager, general manager, 16 people who lived at the home, seven visiting relatives, 16 care staff and four nurses (from both days and nights).

Records looked at across each of the four units included 15 care plans, five staff personnel files, 20 Medication Administration Records (MAR), training records, building/maintenance checks and any relevant

quality assurance documentation. This helped inform our inspection judgements.

Requires Improvement

Is the service safe?

Our findings

We checked to see if people received their medication safely. We found medication was stored in secure trolleys within treatment rooms which were locked at all times to ensure there was no unauthorised access. We noted when medication rounds were in progress, staff administering medication ensured the trolley was never unlocked/unattended. Controlled drugs were being stored securely, with two signatures provided by staff when they were administered to ensure they could be accounted for. Regular temperature checks were maintained of both the medicines fridge and treatment room to ensure medicines did not spoil and lose their effect. PRN (when required) plans were in place to inform staff when medicines such as for pain relief needed to be given and under what circumstances.

During the inspection we looked at 20 medication administration records (MAR) across the four units of the home. Each MAR contained a photograph of the person so they could be easily identified and would assist staff in giving medication to the correct people. On both Park View and Garden Rooms, we found instances where medication had been signed for on the MAR as administered, yet was still in the blister pack when we checked. This meant these people had not received their medication as prescribed which could place them at risk of harm.

Some people living at the home required the use of the drink supplement 'Thick and easy', which is added to people's drinks to make it easier for them to swallow and prevent the risk of choking. This is a prescribed medication and needs to be stored securely, however on Park View unit, we found this being stored in cupboards that weren't locked.

We looked around each of the units to ensure there were no risks or hazards towards people living at the home. On Victoria and Park View units, we found sluice room doors were left unlocked, with access to cleaning fluids. On Victoria unit, the key was still in the door. As with the storage of thick and easy, this meant people could potentially access this and wrongfully consume it, placing themselves at risk of harm, particularly people living with dementia.

The last fire risk assessment carried out in November 2017 had raised a concern of fire doors being wedged open. During the inspection we observed this to still be an area of concern within the home. For instance, we observed two bedroom doors on Victoria Unit wedged open with people's footwear and the small kitchen door held open with a drinks trolley. This meant the doors would not close properly in the event of a fire. The risk assessment also stated corridor areas should remain free from storage, however throughout the first two days of our inspection, particularly early in the morning, we observed corridors to be cluttered with hoists and several wheel chairs. This could affect people's exit in the event of an emergency.

We looked at how people were protected from the risk of skin break down. Each person had a skin care plan and waterlow risk assessment in place which provided an overview of the skin care they required. We reviewed the care plan of one person who had a 'Wound plan' in place due to a pressure sore on their foot and this detailed several actions to be acted upon by staff such as regular changing of their foot dressings and being re-positioned every two hours in bed by staff. They also required the use of a protective boot to

aid the healing process of the pressure sore. We saw these actions were being completed by staff, with records well maintained.

On Victoria unit, we checked to see if people's pressure relieving mattresses were at the correct settings, which should be set according to people's current body weight. In four of the bedrooms we checked, we saw the mattresses were on the wrong setting. For example, in one bedroom the mattress was set to 160kg, however the person's body weight was recorded as only 65kg. We raised this concern with the nurse on duty who said domestic staff must have knocked the settings when cleaning, however there should have been effective oversight of this issue to ensure people weren't being placed at risk.

The concerns regarding medication, pressure care and risks relating to the environment meant there had been a breach of regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safe care and treatment.

We checked to see if their were sufficient numbers of staff deployed to safely meet the needs of people living at the home. The home used a dependency tool to determine how many staff were required on each of the units to care for people safely. In advance of the inspection, we received information of concern about staffing levels on Park View unit. In light of this, we carried out observations on the unit, spoke with staff and reviewed the care records of people living on the unit to establish if this was the case.

Comments from staff on the unit included, "Staffing is not right on here and we have had a lot of people falling. One person had a chair alarm and sleeps in the lounge and if they get up, we have to go and check on them and leave other people. We are always borrowing people from other units which leaves them short."

During the second day of the inspection, we arrived on the unit at approximately 6.45am. Two people were sat alone in the lounge, with two night staff assisting a person in their bedroom. This could place people at risk if they fell when staff were unable to respond quickly due to being in other areas of the home. On the third day of the inspection we noted a member of staff was asked to work on Park View in the morning which left Garden rooms with only three staff instead of four. The member of staff returned to the unit in the afternoon when another member of staff arrived.

Another member of staff said, "We don't always have enough staff. We need three but sometimes we drop down to two. Seven out of the 11 people on this unit require support from two staff. If we are assisting people in bedrooms, then we can't watch people in the lounge area and keep an eye on them. A lot of people need full assistance to eat as well."

We observed meal times on the unit during the second and third day of the inspection. Staffing on the unit consisted of a senior and two care staff. On the second day of our inspection, at lunch time, the senior carer was administering medication to people and both care staff were assisting two people to eat and drink as they required. Another person was seen to move between their bedroom at the far end of the unit and the dining room and had refused to use their zimmer frame to mobilise. They therefore held onto the handrail, their care plan said they needed to be observed by staff when walking up and down the corridor for their safety. However we saw this action was not carried out because staff were busy assisting other people in the dining room.

The same person also had a risk assessment in place regarding entry to other people's bedrooms and being intrusive. Staff needed to monitor them, defuse any conflicts with other people and remove them to another area for their safety. On two occasions, we observed this person laid on another person's bed whilst people

were seated in their room, however it wasn't until we alerted staff that they intervened and persuaded them to leave. At tea time on the third day of the inspection, this person also became involved in a verbal altercation with another resident, however staff were unable to intervene and remove them to another part of the home as described in the risk assessment, due to assisting people to eat and drink. We noted previous incidents between these people had occurred from looking at accident/incident reports.

Shortly after this incident, one person shouted out, "I think I'd like to go for a walk." However, two members of staff who were assisting people to eat told this person to sit back down and would take them later on. This person needed support from staff regarding their mobility. However if sufficient numbers of staff had been available, this person would have been able to go for a walk when they wanted to.

This meant there had been a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards Staffing. This was because sufficient numbers of staff were not always deployed effectively on the unit.

We looked at the systems in place to safeguard people from abuse. The home maintained a log of any safeguarding incidents that had occurred and actions taken. Where allegations of abuse had occurred, minutes of any case conferences/strategy meetings were held, along with notifications sent to CQC. Staff had completed safeguarding training and demonstrated a good understanding of what constituted abuse and how to report concerns.

Overall, we found any allegations of abuse were reported through to the local authority for further investigation. However one member of staff told us they had raised concerns about another member of staff, as they felt they had observed them behaving in a threatening way towards a person living at the home. This had been reported to the registered manager, however they were concerned because they had not received any feedback about what had happened. We raised this with the registered manager who had spoken to the alleged abuser and taken a statement from them, however not from the member of staff who witnessed the incident, no other action had been taken.. The registered manager told us a safeguarding alert had not been raised, however this was done following the inspection, with a CQC notification also sent.

This meant there had been a breach of regulation 13 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards Safeguarding people from abuse and improper treatment. This was because systems and processes were not operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

We checked to see if the premises were being well maintained to ensure they were safe for people to use. Since October 2017, the home was in the process of being re-furbished an we noted improvements had been made to the home environment. This included the reception area, the replacement of the lift, replacement of some windows, chairs and laundry equipment. Park View unit was also being re-decorated at the time of our inspection.

Further work was still required however and we noted several of the units needed new arm chairs, window frames and carpets. We found the Lowry unit in particular was still in need of refurbishment in several areas. For instance, we saw windows in the lounge were nailed shut because they no longer operated effectively. Many of the window frames were wooden and damaged and needed to be replaced. Carpets in the lounge were stained and worn and some chairs were cracked which posed the risk of them not being able to be cleaned properly. The window in the lounge/dining area on Park View was also rotten, with chipped paint work. The internal garden area which is overlooked from Lowry unit appeared overgrown and would benefit from additional work to improve its appearance.

We will monitor the progress of this refurbishment plan and report on any improvements at our next inspection.

We looked at the systems in place regarding accidents and incidents. We saw individual forms were completed and detailed any actions taken by staff. Trends analysis was undertaken to monitor any re-occurring themes across the units which would help staff to determine if people were having more frequent accidents such as falls.

We looked at the systems in place regarding recruitment of staff and reviewed five staff personnel files during the inspection. Each file we looked at contained evidence of job application forms, interview questions/responses, photographic identification, references from previous employers and disclosure barring service (DBS) checks. These checks would ensure staff were of good character and suitable to work with vulnerable people.

We looked at how people were supported to reduce the risk of falls. We noted people had appropriate mobility care plans and risk assessments in place which provided an overview of their requirements. In one person's records, their care plan clearly described how bed rails shouldn't be used as they were at risk of climbing over them and placing themselves at risk. They also needed a crash mat in place so that if they did fall from bed, injury could be prevented. We checked this person in their bedroom and saw these measures were being followed by staff.

We checked to see if equipment and the building were being well maintained. We found appropriate checks and work had been undertaken regarding gas safety, the fire alarm system, electrical installation, legionella and hoists. The certificates of work completed were available and held within an organised file. This would ensure the premises were safe for people to use.

Requires Improvement

Is the service effective?

Our findings

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 to 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 to see if staff at the home were working within the requirements of DoLS/MCA.

The home maintained a matrix regarding DoLS applications and we saw the majority had been applied for when people lacked the capacity to provide consent to their care and treatment and were unable to leave the home safely. However we noted one person who had been living at the home since January 2017, did not have a DoLS in place despite lacking capacity. We raised this with the general manager who made this application during the first day of the inspection. This meant the person had been living at the home without lawful authority, as they would not be free to leave.

We checked to see if any restrictive practices were in use and if so, whether they were in people's best interest. We observed one person on Victoria unit, who had been assessed as lacking capacity, sat in a recliner chair, which would make it difficult for them to get out of if they wanted to. The manager told us this person liked sitting in this chair. Staff said the person had forgotten they couldn't walk and may try to get up. This person also had a sensor mat in place to alert staff if they attempted to move from their chair. This was used as safety measure, however it is a restrictive practice as it restricts the person's movements and alerts staff to their whereabouts. We asked the registered manager if the decision to use this equipment and chair had been made as part of a best interest decision, however at the the time of the inspection this had not been done. A decision specific capacity assessment had also not been undertaken.

This meant there had been a breach of regulation 13 (4 and 5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to safeguarding people from abuse and improper treatment.

During the inspection we observed staff seeking consent from people living at the home before care was delivered. This included offering people protective clothing at meal times, assisting people at meal times and asking people where they would like to sit. This meant people were being given the opportunity to state whether or not they received care at that time.

We looked at the staff induction programme. This included the Skills for Care Certificate which was developed by a recognised workforce development body for adult social care in England. The certificate is a set of standards that health and social care workers are expected to adhere to in their daily working life. All

of the staff we spoke with said an induction was provided when they first started working at the home and they had found it beneficial in understanding what their job role entailed. One member of staff said, "I was able to shadow existing staff and was shown around the building. Mandatory training was also provided."

Staff told us they received enough training to support them in their roles and courses undertaken were recorded on the training matrix which we reviewed during the inspection. This showed staff had completed training in areas such as safeguarding, moving and handling, dementia care, infection control, fire safety and health and safety. Staff said a mixture of online and face to face training sessions were both available. During the inspection we saw several members of staff attended moving and handling training.. One member of staff said, "Training is all fine and there is plenty to do. They keep on top of it well."

Staff received supervision as part of their ongoing development. We looked at a sample of these records during the inspection and saw they provided a focus on comments from both the supervisor and employee, outcomes, action points and personal targets/objectives. Supervisions were held every three months and we reviewed records from January and April 2018. Appraisals had not yet been undertaken since the home registered under a new provider and the registered manager told us these would be scheduled following the inspection.

We looked at how people's nutrition and hydration needs were being met. We saw people had nutrition care plans and risk assessments in place providing an overview of their dietary needs. People's body weight was kept under review with some people needing to be weighed on either a weekly or monthly basis. Malnutrition Universal Screening Tool (MUST) assessments were completed and provided an overview of the level of risk to people's nutritional status. We saw the drinks trolley came round at regular intervals and people had access to drinks and glasses of juice including people cared for in bed.

We observed several people, being provided meals of the correct consistency identified in their care plans, such as pureed or softer options to make it easier for them to swallow. Staff were aware of which people had any swallowing difficulties and how to support them.

We saw people had been appropriately referred to services such as speech and language therapy (SALT) and dieticians if there were concerns about their nutritional status. Advice and guidance was not always well recorded however. For example, we noted two people on Lowry unit had been provided with nutritional action plans by the dietician, after being referred due to weight loss. One person should have been provided with a milkshake every day, however on the last four weeks food/fluid charts, none had been recorded for this person. The nurse told us milkshakes were given daily and this was likely a recording issue.

A second person was prescribed supplement drinks to be taken three times a day. We checked the same four week period and saw they had only received three supplements on six occasions, with just two being provided on the other days. We asked three staff members about this person's needs, two told us this person should have three supplement drinks a day, whereas the third said they only had two per day. Where these drinks may have been refused, this was not being recorded. We noted there had not been impact on these people's nutritional status such as weight loss and were satisfied this was a recording issue.

We have addressed this recording concern within the responsive section of this report.

We saw there were some adaptions to the environment, which included pictorial signs on the doors and contrasting coloured grab rails in some of the bathrooms which would assist people living with a diagnosis of dementia to orientate around the building and find their own room. On Lowry Unit, which cared for people with dementia, themed corridors had been introduced with pictures of famous actors, the queen,

sporting memorabilia and famous singers. There were sensory objects people could touch. This would help people to become more familiar with the environment they lived in.

People living at the home and their relatives told us the home worked well with other healthcare professionals and sought their advice when required. People's care plans also contained details of the professionals that had been involved in people's care, any appointments attended and if people had received treatment within the home.

Good

Is the service caring?

Our findings

We asked the people living at the home if they felt they were receiving good care whilst living at The Fountains Nursing Home. One person said, "I feel cared for. I've got everything I need here. Staff listen to me. If I can't do anything they help me. Lovely people, I'm very happy. Staff knock to come in. Very kind to me. Best thing I've done is coming to live here." Another person said, "I have lived here for four years and I feel like I am receiving good care. The staff are all okay with me."

The visiting relatives we spoke with said they were happy with the care being provided. One relative said, "When I come in to visit I haven't seen anything that concerns me. Staff are very welcoming. People are treated well. " Another relative said, "My relation has been here for six years and I can't fault it. Never once have I heard staff raising their voice towards residents. I feel I can go away from the home knowing everything is fine. I really do feel that she is alright living here."

During the inspection we observed kind and caring interactions between staff and people living at the home. People spoke fondly of the staff who cared for them and we observed occasions where there were appropriate kisses on the head and staff putting their arms around people to comfort them. One relative said to us, "The staff are marvellous and have patience with people. Despite them being run off their feet at times, they do a fantastic job." Another relative said, "The staff are very caring and seem to know people well."

We observed people looking clean and well presented and we did not see anybody looking dirty or unkempt. One person was wearing some of their favourite jewellery, with staff commenting how nice they looked. We saw on several occasions, people had spilt food on their clothing, however staff responded quickly and helped people to change their clothes. One relative said, "When I visit, mum does always look clean. Her finger nails are always clean and she is wearing different clothes."

We observed people being treated with dignity and respect during the inspection. We saw people taken away from communal areas to receive personal care and saw staff knocking on doors before entering people's bedrooms. During the inspection, we observed one person being transferred in a hoist, however their legs became exposed and we saw a member of staff quickly cover them up. A relative said to us, "Absolutely treated with respect. Her bedroom and bed sheets are always clean as well."

Staff promoted people's independence where possible and we saw people being able to continue doing things for themselves during the inspection. This included things such as eating and drinking and mobilising around the building on their own if they were able to. One person told us how staff added toothpaste to their brush each morning and night so they could brush their own teeth independently and told us this was something they liked doing. Staff offered people choice about how they spent their day and we saw staff giving people the choice about where they wanted to sit and what they would like to eat at meal times.

We looked to see how the provider promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though good person-centred care

planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs. For example if people had been referred to the home who required an alternative diet the service had responded appropriately.

We read a series of compliments which had been made by visiting friends and relatives, some of which read, 'To all of the staff at The Fountains, I am writing to thank you for the last five and half years looking after my husband. Words alone cannot express my gratitude.' and 'To everyone at The Fountains, thank you for everything you have done for me. I truly appreciate it and I will never forget you.' and 'Just a little note to say thank you for the care and compassion during my mum's stay. You have been brilliant.'

Requires Improvement

Is the service responsive?

Our findings

We checked to see if the home were responsive towards people's needs and provided care that met their requirements and reflected their preferences.

We observed one person on Park View unit who had swollen ankles and feet. We reviewed their care plan to determine what staff needed to do to reduce the swelling, however nothing had been documented for staff to follow. The person's feet weren't elevated and were placed on the floor. During the second day of the inspection, we raised the issue with staff who then produced a small foot stool and said this should be used to elevate the person's feet. We asked why this wasn't being used consistently and were told the person refused to elevate their feet, however we had been observing this person throughout the day and saw staff had not attempted to do this. On the third day of the inspection, the person was seen again with their feet not elevated and the foot stool at the other side of the room. This meant the person could have been in discomfort due to the swelling in their feet.

The same person also had a social interaction care plan in place which stated staff should encourage them to interact with other residents, however as we had been observing this person, we saw they remained seated in the same chair throughout the day and behind the main seating area, with staff not offering them the opportunity to sit with others. This meant the person could be at risk of social isolation.

We reviewed the moving and handling assessment of one person which stated they required two members of staff to assist them when standing from their chair. However when observing this person during the second day of the inspection, we saw them being supported by only one member of staff. We raised this with the general manager who said this could vary depending on the person's mood that day, however this was not clearly documented in their care plan. This meant there was a risk this person's moving and handling requirements were not being effectively met.

During the first day of the inspection, on Lowry unit, we observed a member of staff asking a person where their glasses were. Numerous pairs of glasses were set out on a table close by and the member of staff sorted through them, placed one of the pairs of glasses on the person's face and asked if they could see through them. The person said yes and the member of staff then left them on their face. This meant the person's vision could have been affected due to them not wearing the correct glasses.

Another person living at the home had an eating and drinking care plan in place which stated they needed a plate guard in place at meal times to prevent them from spilling their food, however observations at meal times were that this was not provided for them.

This meant there had been a breach of regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to person centred care. This was because the care people received did not always meet their needs.

During the inspection, we looked at the care plans of 15 people who lived at the home. Each care plan

covered areas such as nutrition, mobility, skin care, elimination, sleeping and communication. The care plans we looked at were reviewed on a monthly basis by staff to check the information was still accurate. People had separate personal care charts in use which covered areas such as when people received a bath/shower, had their nails cleaned or had their hair cut.
We found instances where important information was not captured within people's care plans and records relating to people's personal care requirements were not always documented. For example, one person had a continence assessment which stated they were continent and because of this, the rest of their continence assessment had not been completed. However when speaking with staff about this person, it later transpired they were incontinent and that the assessment was not accurate.

In two of the care plans we reviewed, the oral care and washing/dressing section stated staff needed to provide assistance and encouragement to these people to maintain good oral hygiene. However, records regarding people having their teeth and dentures cleaned were not always being well maintained by staff. This meant we were unable to determine if this aspect of people's personal care had been carried out.

As referenced in the effective section of this report, we also found recording concerns in relation to how frequently people received dietary supplements to help them gain weight, as prescribed by the dietician.

This meant there had been a breach of regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to good governance. This was because their had been a failure to maintain an accurate, complete and contemporaneous record in respect of each service user.

We looked at the activities available to people within the home. We saw a detailed activity schedule was on display on the units, which listed morning and afternoon activities seven days per week, however staff told us this was not always followed. The home had an activities co-ordinator, however we were told they tended to spend a lot of their time helping out with care and completing paperwork, rather than facilitating activities.

On the first day of inspection, the home ran a gardening club activity which was held on Garden Rooms. People from the other units were asked if they would like to attend and were assisted down by staff. On other occasions we saw several one to one activities taking place, such as staff sitting with people and looking at reminiscence books. One person living at the home said, "There is something to do if you want to. There isn't a plan, she comes around and says, are you coming to do whatever it is that's on. You can say yes or no. Staff do chat sometimes. I go over to the park. It's nice in there. If I need any shopping I go out for it. I've no complaints. If I did I can speak to anyone. Staff do ask me all the time if I'm ok."

The home had a clear complaints policy and procedure which they had followed. There was a log of complaints received, details of the actions taken and outcomes achieved. Information about how to make a complaint and who to contact was displayed in the reception area. People living in the home and their relatives were aware of how to raise their concerns or complaints and felt they would be acted upon appropriately.

There were systems in place to seek feedback from people living at the home and their relatives. This included residents/relatives meetings, with topics of discussion including concerns/compliments, previous CQC reports, management arrangements and any feedback about the home. The most recent satisfaction survey was in the process of being sent out at the time of the inspection and we will review the response to this at our next comprehensive inspection.

A separate survey had been sent out regarding the food provided at the home. Based on the responses, it

was not clear to us how any negative feedback had been acted upon. The registered manager told us it had been responded to, but was not documented anywhere.

We recommend the home introduces a system to demonstrate how information from satisfaction surveys is listened to and acted upon.

We looked at the care people received towards the end of their life. We looked at the records of one person who was receiving end of life care. We spoke with the nurse who told us the person received regular visits from the palliative care team who had last visited the week prior to our inspection. The nurse described to us how they aimed to make people as comfortable as possible and ensure people were not in any pain. We observed this person during the inspection and saw they appeared comfortable in bed and were supported with pillows and looked well presented. The nurse told us people's family were allowed to visit as frequently as possible during this time and that special arrangements would be made if required such as staying over night to be with their loved ones.

Requires Improvement

Is the service well-led?

Our findings

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

The Fountains Nursing Home is owned by SPV4 Limited who are the registered provider. There is a staffing structure in place with staff reporting directly either nurses and either the registered/general manager for assistance, help or advice. The work of the home manager was overseen by an area manager and this ensured there were clear lines of accountability within the service.

We looked at the systems in place to monitor the quality of service being provided to ensure good governance. A range of audits were in place at both provider and managerial level and covered areas such as care plans, medication, infection control, health and safety, pressure sores, mattresses and bed rails. These were being completed each month and had been done as recently as May 2018.

We found that improvements were required to overall governance systems to ensure concerns found during this inspection could be identified and acted upon in a timely manner. For instance, effective audits and checks were not in place regarding pressure relieving mattresses and people's personal care records for the first day of the inspection stated mattresses were at the correct setting. A lack of oversight had also impacted in other areas such as the storage of prescribed drink thickeners, sluice room doors being left unlocked, fire doors being wedged open, cluttered corridors compromising people's exit, best interest meetings not being undertaken, DoLS applications not being made and important information in people's care plans not being captured. These had all been some of the concerns found during this inspection.

This meant there had been a breach of regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regards to good governance. This was because there had been a failure to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

We spoke with staff working at the home and asked them about current management and leadership arrangements. We received a mixed response with some staff feeling management and nurses in the home weren't approachable and supportive. One member of staff said, "Sometimes the managers seem like they are in a mood and I feel like I can't approach them. Sometimes I feel like I am being dismissed and that they are not interested. I don't feel like I can go to the nurses with anything. I found some medication once and they said just to throw it in the rubbish bin rather than get rid of it safely. A person was slipping from their chair once and they did nothing to help me and just watched it happen." Another member of staff said, "I am not really happy with management. Not approachable and the office door is always shut. I feel like we get dismissed sometimes and our comments are not listened to."

More positive comments about management from staff included, "Believe me the management is very

good. The manager listens to our problems and does their best. A very good manager from my point of view." Another member of staff said, "The manager is very good from my point of view and knows the job well."

We saw team meetings were conducted across each of the four units within the home. Minutes were taken at all team meetings. We saw actions and matters arising from the previous staff meeting were discussed. Other topics such as documentation, training, support/guidance, uniform, and annual leave had all been agenda items at the meeting. Staff confirmed these meetings were regular and that they felt able to contribute.

CQC had received all the required notifications including those relating to expected/unexpected deaths, serious injuries and known safeguarding concerns. Safeguarding concerns identified during the inspection were sent through via notification shortly after our inspection. This showed a transparent approach and meant we could respond and take any necessary action if required.

Confidential information was being stored securely and we saw records such as care plans and staff personnel files were stored in lockable cabinets when not in use. This meant that people's personal information was kept safe.

The home had policies and procedures in place which covered all aspects of the service. These were developed and updated by the provider. Staff were aware of where these documents were kept and how to access them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Appropriate systems were not in place to ensure people received person centred care that met their care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Appropriate systems were not in place to safeguard people from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not always effectively deployed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate systems were not in place to ensure people received safe care and treatment.

The enforcement action we took:

We issued a warning notice regarding this breach of the regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems were not in place to ensure good governance within the service.

The enforcement action we took:

We issued a warning notice regarding this breach of the regulations.